2019

Occupation-Based Practice in Occupational Therapy

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Occupation-Based Practice in Occupational Therapy

by

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Submitted in partial fulfillment of requirements for the degree of
Doctor of Philosophy in the
Occupational Therapy Department
Dr. Pallavi Patel College of Health Care Sciences
Nova Southeastern University

November 2019

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HEALTH PROFESSIONS DIVISION
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Abstract

Background: The positive impact of occupation and well-being has been documented throughout the literature, however, the direct link of using occupation-based practice (OBP) and improvement of client outcomes has not been well established. This research study considered what OBP is, what the constructs are that comprise it, and how facilitators and barriers impact its use. Results: Results of this grounded theory study included four main constructs of occupation-based practice (actual occupation, meaningful and purposeful value, therapeutic intent, and engaged participation) as well as the theory of Occupational Therapist's Dynamic Use of Occupation-Based Practice. This theory explains the dynamic process that a practitioner uses during each therapeutic interaction and how it impacts where on the continuum the interaction lies (medical model to occupation-based). Conclusion: The results of this study help inform the profession at the academic, continuing education, practice, and administrative levels view and understand occupation-based practice in a more concrete manner. The results of this study provide evidence for the creation of a measurement tool to further assess the use of occupation-based practice.

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Chapter 1: Introduction

From the inception of the profession of occupational therapy, a central and foundational belief has surrounded occupation and its relationship to health (Christiansen & Haertl, 2014; Meyer, 1921/2005; Molineux, 2004). While the profession has gone through multiple paradigm shifts, the initial assumptions of the field remain: (a) that occupation is vital to human life, (b) that there is a direct link between the mind and body, (c) that a lack of occupation can result in poor health or dysfunction, and (d) that engagement in occupation can reestablish health and function (Molineux, 2004). Throughout the past century, the idea in the occupational therapy profession that occupation serves as a means and ends to improve health has waxed and waned, and the current paradigm is moving back to the foundational philosophical beliefs (Christiansen & Haertl, 2014; Gillen, 2013; Gray, 1998). However, even with the encouragement of professional leadership and associations (with the American Occupational Therapy Association providing the most encouragement) to transition back to an occupation-based approach, there continue to be questions and inconsistencies about how occupation is infused into practice.

Background of the Problem

Over the past 100 years of the profession of occupational therapy, there has been the waxing and waning of the central concept of using occupation throughout the therapy process (evaluation, intervention, and outcomes). However, evidence has shown that occupation is a means to healing and good health (Christiansen & Haertl, 2014; Gillen, 2013; Gray, 1998; Hocking, 2009; Wilcock, 2006). Many factors have contributed to this fluctuation in the use and application of occupation in practice, including the inception of Medicare and Medicaid, legislative acts and bills, changes in health care accreditation standards and bodies, and evolving practice settings and populations, to name a few (Christiansen & Haertl, 2014; Gillen, 2013;

Gray, 1998; Reed, 2006; Reed & Peters, 2007, 2008, 2010). In response to the many changes occurring in the profession, society, and the United States culture, the field of occupational therapy has grown and evolved into what it is today. The American Occupational Therapy Association (AOTA), the national association for the profession, has formally expressed a concern through a public statement that practitioners, educators, and researchers need to move practice back to the roots of the profession, back to occupation (AOTA, n.d.b).

A review of the current literature revealed that specific client populations inform the research on occupation-based practice. Therapists working in pediatric settings were educated on the benefits and purpose of infusing occupation throughout practice as its inherent benefit for children became evident (Ericksen, 2010; Estes & Pierce, 2012; Humphrey & Wakeford, 2006). However, there were inconsistent results about how occupation was used throughout practice, even after therapist education on ways to implement occupation in practice. The research illustrated that the better the therapist understood occupation-based practice, the more satisfied the therapist and the client were with the therapy process (Estes & Pierce, 2012). Research with the adult and aging populations also examined the use of occupation-based practice with the support of its application to improve client outcomes, quality of life, and overall improved health (AOTA, 2014a; AOTA, 2016). However, with the support of its use, multiple studies showed its underuse with adults and aging populations (Kennedy, Maddock, Sporrer, & Greene, 2002; Munin et al., 2010). With research supporting the use of occupation-based practice and the paradox as to whether its use is consistent, further exploration is necessary. Research should focus on the constructs that comprise occupation-based practice and the relationships between these constructs.

Purpose of the Study

With the AOTA's focus on occupation-based practice and the question of its use, it is important to investigate further how practitioners define occupation and occupation-based practice and to identify the facilitators and barriers of this fundamental practice. This study's aim is to gain a better understanding of occupation-based practice, the constructs of occupation-based practice, and how those constructs are interconnected. Through this exploration of the extent and process of infusion of occupation into practice, the constructs that comprise occupation-based practice will be better understood.

Current research has not examined practitioner use of occupation, occupation-based practice, the constructs that constitute occupation-based practice, or the relationships between these constructs. There is no mechanism to determine if a therapist, a program, a facility, an educator, or the profession has achieved the goal of using occupation-based practice because of the absence of agreement of what it looks like or how to measure it in an objective manner. Through the use and structure of the grounded theoretical approach, a theory that emerges from the data will be used to develop a model, which may be used as a "yardstick" by which to determine whether occupation-based practice is occurring. This study may also lead to further research and the creation of a measurement tool for quantifying the use of occupation-based practice throughout the field of occupational therapy.

Research Questions

1. What is occupation-based practice, and what does it look like?
2. What are the constructs that make up occupation-based practice, and how are they interconnected?
3. What are the facilitators and barriers to using occupation-based practice?

Operational Definitions

Barrier

Any personal or contextual factor that limits, restrains, obstructs, or hinders the use of occupation-based practice.

Construct

Intangible ideas that are characterized and labeled with no physical reference (such as a place or object) (Miller & Schwartz, 2004).

Facilitator

Any personal or contextual factor that enhances, enables, supports, or assists the use of occupation-based practice.

Occupation

A multifaceted concept that can be described as a collection of activities and roles that a client needs to do, wants to do, or is expected to do in daily life and through time. Occupations provide personal and cultural meaning; are affected by context; change over time; influence identity, health, quality of life, and relationships; and require adaptation (AOTA, 2014b; Price & Miner, 2007).

Occupation-Based Practice

The use of occupational engagement with individuals as the method for evaluations and interventions to reach occupational outcomes (Fisher, 2013).

Occupation as a Means

When occupation is a treatment modality to create improvement in occupational performance as the end goal (Gray, 1998).

Occupation as an Ends

When occupation is the primary goal of occupational therapy intervention; it does not use occupation to improve performance skills but rather to learn or relearn occupations (Gray, 1998).

Assumptions and Limitations of Study

Every study has assumptions and limitations, but with the use of reflexivity and gaining the approval of the Institutional Review Board (IRB) at both Nova Southeastern University and American International College, this researcher will be as unbiased and ethical as possible. As a certified and licensed occupational therapist who is working toward earning a PhD in occupational therapy, I will administer all data collection methods and analyze all data obtained in this study. Because I am an occupational therapist, I assume that occupation-based practice is important and should be used throughout the profession. This previous assumption will be acknowledged yet will be bracketed so that I can be as objective as possible throughout the research study.

This research study will employ a grounded theory approach with the primary guidance of Charmaz's (2014) techniques. While this methodology has its limitations, it also has many strengths. It is useful for organization, analysis, and reporting on qualitative data with a structured approach that many other qualitative research designs do not have. It also will enable me to complete purposeful sampling to gather rich data in exploration of a consequent emerging theory. Multiple variations of data will be collected for the purposes of trustworthiness and triangulation, and I will complete member checks throughout the process. Grounded theory and this research study also have some limitations. These include the inability to relate the results to the larger population of occupational therapists and the lengthy process whereby errors are possible because of the length of time it takes to complete (Charmaz, 2014).

Summary

This research study will address the three main questions: (a) How do therapists conceptualize occupation-based practice, and what does it look like to them? (b) What are the constructs that make up occupation-based practice, and how are they related? and (c) What are the facilitators and barriers to using occupation-based practice? After the review of the history and philosophical base of the profession of occupational therapy, current research, and theoretical concepts, it was noted that there is a gap in the literature regarding occupation-based practice. Using a grounded theory methodology, I will complete interviews and a focus group and use photovoice to further explore occupation-based practice, its constructs and their relationships, and any facilitators or barriers to its use from the perspective of current occupational therapy practitioners.

Chapter 2: Literature Review

A literature review was completed throughout bodies of literature regarding the topics of the history of occupational therapy, occupation, occupation and its relationship to health, occupation-based services and interventions, current practice and research, and the theoretical perspectives that guide current research. Below are the findings of this literature review, which supports the need for the proposed study.

The occupational therapy community operationally defines the term occupation in multiple ways. Pierce (2001) separated experiential and conceptual elements of occupation by defining occupation as "doing something in a specific time, space and sociocultural context, with all the subjective emotions, interpretations, and personally and culturally derived meanings that are entailed" (p. 141). The AOTA defines occupation as the everyday life activities in which people participate (2014b). Occupations provide (a) personal and cultural meaning; (b) are affected by context; (c) change over time; and (d) influence identity, health, quality of life, and relationships (AOTA, 2014b; Hocking, 2009; Price & Miner, 2007). While these explanations vary, they each involve a person purposefully engaging in an occupation. An occupation must provide a person meaning; have a purpose; occur within contexts; have subjective emotions and thoughts; and influence a person's identity, health, and quality of life (AOTA, 2014b; Hocking, 2009; Price & Miner, 2007).

Occupational engagement for human beings provides basic needs, such as a purpose, meaning, choice and control, and self-worth (Hammell, 2004). The use of purposeful occupations that are goal-oriented provides a person with a sense of intention. This purpose could be for social or economic reasons; however, research is unclear if occupation as an intervention is the main reason for an individual's quality of life. Researchers have found that by

providing meaningful occupations to an individual, the individual is more likely to have a sense of value and purpose to life. Occupations also provide people with a sense of choice and control. When an illness or injury disrupts a person's life, the ability to reengage in occupations allows an individual to take control and get back on track. Hammell (2004) describes occupations as providing self-worth to a person. Research has noted that when a person loses the ability to complete chosen occupations, it can decrease positive perceptions of feeling useful and of value. By participating in occupations, a person can fulfill a sense of self-worth and contribute to relationships (Hammell, 2004).

History of Occupational Therapy and Philosophical Transitions

Occupational therapy has been a profession for a century, and throughout this tenure, the focus and view of occupation have evolved in tandem with the growth of health care and the needs of an ever-changing society (Christensen & Haertl, 2014; Trombly, 1995). The profession has grown and evolved with changes in philosophy, theory, intervention focus, and the use of evidence-based practice. It is essential to review the history of the profession, its values, beliefs, and philosophies to understand the concept of occupation-based practice better.

The use of occupation is evident as early as the Greeks, who engaged in occupation to provide educational training and for its therapeutic value (Dunton, 1954). At the end of the 18th and beginning of the 19th centuries, many hospitals aided those with mental health difficulties. In these hospitals, occupation was used to assist in the restoration of the individual's mental health. In the early 1800s, work was done in the United States and England to provide more moral treatment to those with mental health disorders. The use of occupation at this time was often interpreted as labor when patients were assigned domestic work as part of their treatment.

Dr. Kirkbride, from the Pennsylvania Hospital for the Insane at Philadelphia, created a handbook of duties for teachers or companions. In the handbook, he describes the value of occupation:

> It is highly important that patients should, as far as possible, be kept constantly at some pleasant kind of employment—either work of some kind, or riding, walking, or amusements—that no suitable opportunity is ever neglected to induce the patients thus to occupy themselves. (Kirkbride, 1878, as cited in Dunton, 1954, p. 3)

These teachers or companions are regarded as the first occupational therapists and, with time, their work became more organized and centered on using of crafts and other activities with patients (Dunton, 1954).

In the early 1900s, it became clear that a new profession was being formed (Reed, 2006). The basis of the creation of the field of occupational therapy was its healing value of occupation and not specifically new knowledge or technology (Reed, 2006). While multiple disciplines (education, arts and crafts, psychology, engineering, nursing, social services, and medicine) contributed to established the profession, it began with identity issues (Reed, 2006). With the identification that using occupation with patients with mental illnesses had curative properties, occupational therapy was created, and it was primarily found in insane asylums and in general hospitals and used with patients with tuberculosis or clients with orthopedic issues (Christiansen & Haertl, 2014).

During this formative period (1904-1929), the founders of the profession worked to create basic principles to help guide the new profession to create an identity and enter the workforce (Christiansen & Haertl, 2014; Reed, 2006). In 1917, occupational therapy was officially formed when a national organization was founded and entitled the National Society for the Promotion of Occupational Therapy; the organization was later renamed the American

Occupational Therapy Association in 1923 (Christensen & Haertl, 2014). With the inception of the profession, many principles were set, most of which revolved around the use of occupation to heal patients (Reed, 2006). The therapeutic nature of occupation was the core belief because it can be goal-directed; is natural; is imperative for good health; can increase motivation and attention; can improve muscle strength, tone, and joint function; and can be used to improve mental health, self-esteem, and self-worth, among many other positive attributes (Reed, 2006). The term occupation was used most predominantly during the 1920s throughout the literature, thus indicating the major emphasis the profession had with the use of occupation in daily practice (Bauerschmidt & Nelson, 2011). However, as the 1930s and 1940s began, this terminology was quickly changed to activities and work (Bauerschmidt & Nelson, 2011; Reed & Peters, 2006).

The 1930s and 1940s were a tumultuous time in the United States with the Great Depression and WWII (Reed & Peters, 2006). The core values and beliefs of occupational therapy during this period were that of work, activity, normalcy, improving function, increasing health, occupation, and the ability to adjust. During this period, there was also an increased medical alliance when the American Medical Association (AMA) became the accrediting body of the field. A physician led the AOTA and new regulations were instituted that required an occupational therapist to work directly under the supervision of a physician, mandated a patient receive a prescription for occupational therapy services, and incorporated more medical model language into practice (i.e., prescribed, dosage of treatment, strength, range of motion, etc.). This medical alliance had both positive and negative effects. By having the AMA regulate occupational therapy, there were standards created for training future therapists, the accreditation of approved schools, and increased access to services at hospitals for both chronically and

acutely ill patients. However, because of the medical model changes, the field was grouped with physical therapy and was given the second priority when it came to billing (Reed & Peters, 2006).

The 1930s and 1940s were also a time in which the types of clients treated increased (Reed & Peters, 2006). In prior years, therapists worked in curative workshops; conducted habit training and mental hygiene; used occupation for its therapeutic values; and worked with those with mental illnesses, tuberculosis, and orthopedic issues. While those areas remained active throughout this time, there was also the inclusion of pediatrics (cerebral palsy, cardiac conditions, and poliomyelitis) with the focus ranging from diversion to training for function (Reed & Peters, 2006). The other significant area of growth was that of working with injured soldiers who had returned from war. With this population, there was a rise in rehabilitation, and physical medicine influenced therapists to begin to adopt medical model practices, facilitating strength, endurance, and range of motion while doing crafts (Christiansen & Haertl, 2014). This era transitioned the core philosophy from occupation to medical model and the focus of soldiers returning to work.

In the 1950s and 1960s, the profession continued to move toward scientific methods and away from arts and crafts (Christiansen & Haertl, 2014). Mary Reilly summarized a theme for the vast changes that were about to come with the profession becoming more science-based and less about arts and crafts (Reed & Peters, 2007). The arts and crafts movement was about unity; enjoying work; creating individualism; social accountability; having simplicity, but with order; and the values of the family. However, with the changes in medicine and social reform in the United States, the field of medicine had changed drastically and focused on the use of scientific methods and the use of research (Reed & Peters, 2007). The focus also transitioned from long-

term care (arts and crafts) to short-term or acute illnesses (biomedical). The primary role of occupational therapy transitioned to improving or increasing coordination, strength, range of motion, muscle power, and decreased tone or tightness, all while working toward getting a client to be as functional as possible. This biomedical focus was more on the medical aspects of the patient and less about the social or temporal components. The development and implementation of Medicare and Medicaid had a significant influence on this focus model. This led to substantial changes in the profession's definition, practice areas, education, research, and organization (Reed & Peters, 2007).

For the first time in the profession's history, the AOTA approved a formal definition of occupational therapy: "Occupational Therapy is the art and science of directing man's response to selected activity to promote and maintain health, to prevent disability, to evaluate behavior and to treat or train patients with physical or psychosocial dysfunction" (AOTA, 1969, p. 185, as cited in Reed & Peters, 2007). Of note, there is no mention of occupation in this definition or of a biomedical approach (Reed & Peters, 2007). Another advancement that the association made was having occupational therapy publications written by occupational therapists rather than physicians. Individuals with tuberculosis and polio were drastically declining; thus, new practice areas emerged and included areas of neurology, perceptual-motor, dysfunction, neurophysiology, and increasing facilitation techniques. The other area that developed and was adopted quickly was that of activities of daily living (ADLs). ADLs the things that a person does for themselves so that they are not miserable (Reed & Peters, 2007). These concepts increased the value of independence and brought living independently to the forefront (Reed & Peters, 2007).

These two decades was also a time for advocating for the profession and education (Reed & Peters, 2007). Physicians now made referrals rather than prescribing specific interventions.

Licensure by the state was proposed, but quickly refuted by the AOTA, and in 1963, a baccalaureate degree was required to become an occupational therapist. A discussion about graduate education was underway, as some felt the need to assist the field in promoting more scholarship, and certified occupational therapy assistants were trained and entered the workforce for the first time. With the passing of the Social Security Act Amendments of 1965, coverage for occupational therapy services became available in hospitals and considered a secondary service in home health (Reed & Peters, 2008). While there was extreme growth for the profession, the focus remained in the medical model and was concentrated on research development, education program growth, and technical and professional practitioners and less on model and theory development around the use of occupations (Reed & Peters, 2007).

In the 1970s and 1980s, the profession struggled with its own identity in multiple ways (Reed & Peters, 2008). There were identity issues in regard to who had control over practitioners (whether it should remain the AOTA or an external body), issues with professional visibility and usefulness versus insignificance, research emphasis versus theory building, whether the profession should be professional or semi-professional, and whether there was role confusion between occupational therapists and occupational therapy assistants (Reed & Peters, 2008). The controversial issue of state licensure remained until, in 1974, state licensure was promoted. With its implementation came an increase in recognition by multiple payer sources and a formal, legal, occupational therapy definition. In 1975, the AOTA developed a Model Occupational Therapy Act, which led practitioners to begin writing their own state licensure bills. Other important pieces of legislation that were passed during this time were: (a) the Education for All Handicapped Children Act that specifically included occupational therapy and (b) the Rehabilitation Act of 1973 with Amendments in 1978 that did not include occupational therapy,

even with its major focus being described as individuals living independently. Regardless of the legislation, the field grew 135% in occupational therapists and 199% in occupational therapy assistants. With this massive growth, an increase in professional values and beliefs, as well as better delineation of occupational therapists versus assistants, were needed (Reed & Peters, 2008).

During this time, Medicare and Medicaid updated their regulations regarding occupational therapy, and in 1980 they upgraded the services to primary status in which it could be ordered as a single service, included in comprehensive rehabilitation programs, and created the opportunity for private practices to begin (Reed & Peters, 2008). However, there was much controversy over whether private insurance companies would pay for occupational therapy services. This controversy required therapists to prove medical necessity for all services, which, in turn, increased the amount of medical terminology rather than occupation-based phrases. In 1982, Connecticut was the first state to require private insurance to reimburse for occupational therapy services, and while there were official definitions of occupational therapy versus physical therapy, there was still much confusion between the two services. Because of some of these identity issues, the profession was forced to make some difficult decisions regarding research versus theory, how professional the profession should be, and how to provide role definitions (Reed & Peters, 2008).

Although the profession developed from multiple disciplines and the focus was the apprentice model, in the 1970s practitioners decided to create a “professional” status with documents, such as the Code of Ethics and the Philosophical Base of Occupational Therapy project (Reed & Peters, 2008). There was also a push to better delineate the differences between an occupational therapist and an occupational therapy assistant with the approval of The

Delineation of the Role of Entry-Level Occupational Therapy Personnel. These documents and initiative helped create a stronger commitment to research, increased the number of standardized measurement tools, and published new models of practice. These were significant outcomes; however, the controversy of whether to stay focused on the medical model or move back to the holistic (occupation-based) perspective of the founding members of the profession remained (Reed & Peters, 2008).

In the 1990s and 2000s, there multiple concerns that had emerged throughout the history of the profession that remained unresolved (Reed & Peters, 2010). Academia was officially identified as a practice area with the need for academicians to complete additional education, teach, and publish research and textbooks. The differentiation of credentialing, certification, and membership were finally resolved with the creation of the National Board for Certification in Occupational Therapy (NBCOT), state licensure for credentialing, and the AOTA having a voluntary membership. While it was important to keep these separate and allow for a clean break from the AMA, it also caused confusion and a reduction in the AOTA membership. This required the AOTA to prove to its members the worth that the association could provide to practitioners. With the disbanded alliance with the AMA, the profession was at a pivotal point on how to continue to grow (Reed & Peters, 2010).

The profession of occupational therapy officially was no longer under the AMA's umbrella policy as of 1992 (Christensen & Haertl, 2014; Reed & Peters, 2010). The field had to decide whether to remain in the rehabilitation field with a focus on medical rehabilitation (with a disease focus) or to create a self-definition that focused on health and wellness. Practitioners finally came to the decision that the field should shift to helping clients be in good health and to lead satisfying lives through occupational engagement to achieve goals and desired mastery of

contexts. This required the profession to expand on theories and conceptual models to better understand the profession. With these choices, the field also had to figure out how to improve job satisfaction and create more therapists with a refocus on occupation and its therapeutic value (Christensen & Haertl, 2014; Reed & Peters, 2010).

During this time, the AOTA completed a study on the number of personnel in the field (now called the workforce studies [2015]), which indicated a substantial underrepresentation and various levels of practitioners based on locations (Reed & Peters, 2010). This led to further investigation with findings of a lack of faculty to educate incoming students, a decline in the number of students applying to academic programs, insufficient fieldwork sites, larger populations to serve, new areas of practice being found, and the need for more research to support practice. With this time of change and a need for growth, the profession and its leaders pushed for a return to using occupation to treat clients. The publication of research studies supporting the use of occupation as the bedrock of occupational therapy validated the need to change how therapy was practiced (Reed & Peters, 2010).

From the 1990s and early 2000s to the present, there has been a shift in the field to focus on client-centered practices, the use of occupational science as a foundation for the profession, and a movement back to the use of occupation as a curative or healing practice. There has been an increase in the creation and implementation of evidence-based practice, focus on prevention and promotion, and further development of theories and conceptual models to guide therapists' practice (Christiansen & Haertl, 2014).

Gillen (2013) argued that there were multiple times in our history that we lost sight of our intervention methods, assessment approaches, and the broad focus of our profession. An example was in the 1940s and 1950s when the field of occupational therapy concentrated on techniques

such as skill-building and relearning, rather than the act of incorporating the clients' perceived abilities and the act of doing. The profession has had role confusion over the years, where we tried emulating other professions rather than remaining true to the core beliefs of occupational therapy. To preserve and clearly define our discipline, we must practice what we preach (Gillen, 2013). A reversion back to the profession's roots with the insertion of "occupation back into occupational therapy" (p. 650) requires several changes in practice throughout the occupational therapy process. Changes that would foster a return to occupation-based roots require therapists to adjust practice with an increased use of occupation and performance-based assessments, an increase of occupation in interventions, and facilitation of active engagement of the client rather than the therapists doing to the client (Gillen, 2013). It would also necessitate the maintenance of pride and confidence in the profession and infusion of real-world activities to return clients to their normalcy (Gillen, 2013). A philosophical shift in perspective would also foster a return to the profession's core beliefs transitioning from practitioners asking, "What's the matter with you?" to "What matters to you?" (AOTA, n.d.a.).

Occupation in Health

With the medically focused health care system in the United States, it can be difficult for other health care disciplines and consumers to associate the link between occupation and health (Wilcock, 2006). While it has not been as emphasized in the literature and throughout practice, the relationship between occupation and health has been known for many years (Hocking, 2009). With the question of the therapist's understanding and application of occupation, the literature on occupation and its impact on overall health and well-being has gradually increased as understanding and recognition has improved (Reed, Hocking, & Smythe, 2013). With increased

recognition, evidence continues to grow in support of occupations supporting psychological, physical, spiritual, cognitive, and social well-being (Hocking, 2009).

While there is evidence that links a person's overall health and well-being to engagement in occupations (Jackson, Carlson, Mandel, Zemke, & Clark, 1998), there continues to be insufficient evidence to create a direct causation of using occupation to improve health (Wilcock, 2007). Wilcock argues that there is evidence to support health through occupation all around us (2007). There have been studies that support modern concepts of health with social and productive activities having the same benefits to health as exercise. Wilcock further acknowledges that for more than 30 years, the World Health Organization (WHO; n.d.) has based their policies on how a person is able to engage in occupations, how a person feels about those occupations, and the meaning of the occupations completed. Based on those components, the WHO (n.d.) further discusses how the interaction of these components can be health-promoting. Literature has stated that by using occupation-based interventions in the field of occupational therapy, consumers can have improved health and well-being (Hocking, 2009; Wilcock, 2007).

Occupation-Based Intervention

With the inconsistency of understanding and a lack of infusion of occupation in occupational therapy practice, there is also confusion with its terminology. While there are multiple terms and phrases used to describe occupation and its use in practice, occupation-based will be operationally defined throughout this research. Occupation-based is defined as the use of occupational engagement with individuals as the method for evaluations and interventions to reach occupational outcomes (Fisher, 2013). There have been multiple advantages cited in the literature in support of using occupation-based programming, which includes sending a strong

message to others about who occupational therapists are and what they do when working with clients. Another benefit to occupation-based intervention is that it enhances client outcomes by including a way to evaluate the quality of occupational performance; occupations can occur as they do in everyday life, and therapists should match them to each client's specific goals to provide a sense of enjoyment, accomplishment, and renewal. By using occupation as the foundation of all interventions and evaluations, clients engage in meaningful and purposeful daily life tasks with the primary means of returning to health and increasing their well-being (Fisher, 2013).

Current Practice

The AOTA is the guiding professional body for the field of occupational therapy that represents practitioner and student interests to progress the quality of occupational therapy services continuously (n.d.a). The AOTA is also dedicated to (a) ensuring that occupational therapy services are of quality, (b) increasing access to health care services, (c) promoting evidence-based practice, and (d) building the body of research to further enhance practice (AOTA, n.d.a). Research throughout the health care fields in recent years has begun to highlight occupation-based practice; this will be discussed further.

AOTA Initiatives

The AOTA has created the centennial vision with identified areas of key practice areas to focus on in this century (AOTA, n.d.b). One of the areas the AOTA is currently discussing is productive aging, which was identified because of the rapid growth in the aging of the baby boomer population and increased their longevity. The aging population is focused more on their quality of life and the desire to age in place (living at home and in the community) than ever before. The field of occupational therapy can address this initiative through the use of

occupation-based interventions by assisting the older population with (a) driving safely or assisting with other modes of transportation; (b) chronic conditions, such as diabetes, arthritis, pain, and chronic disease management; (c) dementia and Alzheimer's disease; (d) fall prevention; (e) home modifications; (f) mental health issues; (g) living after having a stroke; and (h) providing assistive technology devices and/or services. While this is not a comprehensive list of areas an occupational therapist can address, it does align with the WHO global initiatives. This is just one of the many areas the AOTA is discussing to move practice back to being occupation-based throughout the health care continuum (AOTA, n.d.b).

Current Research

Current practice throughout the health care continuum has limited research and data regarding specific types of interventions used (preparatory versus activities and occupations). Rogers (2007) has noted that even with the encouragement for therapists to use more occupation-based interventions in daily practice, students participating in fieldwork are reporting to educational programs that they are seeing mostly preparatory methods and tasks. It is crucial to consider the medical model constraints on occupation-based intervention, such as difficulty billing, productivity requirements, and documentation expectations of various facilities (Rogers, 2007). Current research has also focused primarily on client-specific populations, treatment types and modalities, and reflections of our clients and patients, rather than the therapist's perspectives of his or her use of occupation-based practice (Aiken, Fourt, Cheng, & Polatajko, 2011).

Pediatrics

Practitioners working with pediatric populations are continually encouraged to use occupation-based practice in daily interventions. Research has noted that practitioner's perceptions of using occupation-based practice were the most significant contributing factor to

whether they found value in occupation as a means and ends (Ericksen, 2010; Estes & Pierce, 2012; Humphrey & Wakeford, 2006). The research was inconsistent as to whether occupational therapists valued occupation-based practice enough to use it on a regular basis; however, if using occupation-based interventions there were better individualized and effective treatments (Ericksen, 2010; Estes & Pierce, 2012; Humphrey & Wakeford, 2006).

A study completed by Estes and Pierce (2012) examined pediatric therapists use and perspectives of occupation-based practice. The researchers used a grounded theory approach, with findings indicating that education and personal identity influenced the use of occupation-based practice. They also found therapists reported that when they used occupation as a focus in daily practice, it was more gratifying and satisfying as a therapist. Finally, the researchers found therapists who used occupation-based practice saw their clients progress more and could create more individualized interventions (Estes & Pierce, 2012).

Ericksen (2010) described a single case of a public-school district transitioning to a more client-centered and occupation-based focus in a suburban area in the United States. The author used 2001 as a baseline to gather data on current practice in the school and noted a lack of theoretical knowledge and occupation-based assessment tools (but rather more based on body functions and performance skills). She completed a year of workshops for all practitioners, educating them on theories, frames of reference, and models of practice in the field of occupational therapy. She then implemented the use of the School Version of the Assessment of the Motor and Process Skills (School AMPS) through multiple educational courses and then throughout the school system. The 5-year process revealed that although changes occurred, the more significant barrier to implementing the changes was the practitioners themselves. The author did note that the value of occupation in the school system had increased, and that more

therapists were using it than were not; however, continued emphasis is needed throughout all school systems in the United States (Ericksen, 2010).

A third article, by Humphry and Wakeford (2006), discussed the concept of childhood and human development occurring through occupations. The authors argued that occupational therapy practitioners should use occupation-based practice to support childhood development rather than focusing on the various developmental theories used in occupational therapy (interactionism, contextual, or dynamic systems theory). After applying models to a single case subject, the authors noted that if a practitioner can focus on the interconnectedness of the person and the occupation, then interventions will be effective and well-designed to support occupational performance (Humphry & Wakeford, 2006).

Adults and Aging

Multiple research articles support the use of occupation-based practice and how it can improve client outcomes, quality of life, and overall improved health for the adult and aging populations (AOTA, 2014a; AOTA, 2016). However, the studies also noted that therapists have a difficult time defining what occupations were in the medical field (Munin et al., 2010). Many practitioners reported completing almost half of all interventions for upper extremity strengthening through exercise (Munin et al., 2010), while others noted that billing restraints (from Medicare) and required outcome measures (Functional Independence Measure) compelled them to chose interventions that were less occupation-based and more medically focused (Gray, 1998; Kennedy et al., 2002).

Munin et al. (2010) completed a research study on the types of interventions provided to patients who were status post-hip replacement. Both occupational and physical therapy interventions were analyzed, with the most frequent types of intervention being identified. The

four most common interventions used in occupational therapy sessions included exercise, transfers, lower extremity dressing, and functional mobility. While lower extremity dressing is the only clear occupation-based intervention, transfers were identified as being to and from the toilet, bathtub, and bed. However, it was indicated that upper extremity exercise took up 40% of the overall treatment time (Munin et al., 2010).

Another study completed by Kennedy, Maddock, Sporrer, and Greene (2002) examined the changes resulting from the Medicare billing system in relation to the types of interventions used in skilled nursing facilities (2002). Through this pilot study, the authors found that occupational therapists changed their intervention focus because of the Medicare billing system. Therapists moved away from ADLs and more toward biomechanical interventions with reports of perceiving it to be more difficult to provide client-centered practice. The conclusion was that there is a discrepancy between the AOTA ideals and what is occurring in actual practice in skilled nursing facilities (Kennedy et al., 2002).

Many rehabilitation facilities have reduced the concepts of ADLs down to Functional Independence Measure (FIM) scores, rather than including the all-encompassing nature of ADLs (Gray, 1998). While using an occupation-based approach can be difficult and demanding, because of the current nature of today's health care world, it is imperative for occupational therapists to maintain the core focus of occupation as therapeutic evaluation and intervention (Gray, 1998).

Research regarding the use of occupation-based interventions and measurement tools for the aging population has been completed most frequently with specific populations. In the critically appraised topics (CAT) on Alzheimer's disease and related disorders, 13 research studies were analyzed (AOTA, 2016). The researchers found that the use of occupation-based

interventions improved or prevented further decline in daily occupations for this population. This CAT supports the use of occupation-based interventions consistently during occupational therapy services with those diagnosed with dementia-related diseases (AOTA, 2016).

Another CAT completed on adults living after having a stroke was to analyze the effectiveness of occupation-based interventions during occupational therapy treatment (AOTA, 2014a). This CAT reviewed 39 research articles with the conclusion of occupation-based interventions progressing client outcomes in the area of ADLs. There were mixed results in relationship to independent activities of daily living (IADLs) performance, secondary to the small number of research studies, the use of virtual reality as a main intervention, and not addressing many areas of IADL performance (sexual functioning, driving rehabilitation, or activity-based community interventions). Only six studies researched leisure, social participation, and rest/sleep outcomes, with two providing evidence that occupation-based leisure interventions improved the client's leisure participation (AOTA, 2014a).

Another systematic review was completed on 98 peer-reviewed journal articles to examine occupational engagement and health outcomes in community-living older adults (Stav, Hallenen, Lane, & Arbesman, 2012). The results of this systematic review supported that participation in occupations has a positive influence on health and quality of life for older adults. The authors also stated that there is a need for the current health care systems to reevaluate current practices to meet the future demands of this population. By providing occupation-based interventions and outcomes throughout the health care continuum with the aging population, occupational therapists can have a positive impact on their health and well-being (Stav et al., 2012).

Theoretical Perspectives

Theoretical guidance for research is considered best practice and a necessary step in the planning and execution of completing any type of research (Caelli, Ray, & Mill, 2003; Crotty, 2013). By using theoretical frameworks, research can be shaped using already researched concepts to enhance methodology design, results, and discussion for application. Many theoretical constructs are available; however, by using the occupational perspective of health model (OPH; Wilcock, 2006) and the diffusion of innovation model (Rogers, 2003), occupation-based practice can further be examined as to how its use is occurring in practice and the values practitioners have surrounding its use.

Occupational Perspectives of Health (OPH)

Many researchers have examined the importance of meaning and participating in occupations; however, the most well-known theory in occupational science is that of Wilcock's theory of the OPH (2006). The OPH provides a framework for the complex relationship between the person, occupation, environment, and well-being (Ekelman, Bazyk, & Bazyk, 2013). Wilcock's model has four main constructs that provide the underlying concepts of occupation that can promote or hinder the health and well-being of an individual (Hitch, Pepin, & Stagnitti, 2014; Wilcock, 2006). The concepts of doing, being, becoming, and belonging are central to the OPH and can be applied throughout any population to enhance how practitioners understand and work with clients using client-centered and occupation-based practice approaches.

Doing is characterized as being active in occupational engagement that is meaningful and may be purposeful to the individual completing the occupations (Hitch et al., 2014). It includes the skills and abilities needed for future doing, which are beyond those needed for survival. Doing is generally comparable across the population, and persons can adjust their doing

according to changing situations. This is the most concrete of the components of the OPH because of the observable nature of occupational engagement (Hitch et al., 2014).

Being as essence is "how people feel about what they do" (Wilcock, 2006, p. 113) and is purely spiritual, psychological, and philosophical in nature (Hitch et al., 2014). It is the least tangible because of its changing, fluctuating, and transforming nature during occupational engagement (Hitch et al., 2014). It is considered the most prominent construct of the model and can be used in three different ways: being as essence, being as entity, and being as existing. Being as entity is the sense of who a person is as an occupational being. These personally interpreted ideas can be facilitators or barriers to change and are essential to the role of a person's capacities in encouraging and directing an individual's occupational engagement. Being as existing is a time of reflection, self-discovery, and thinking; it is inactive and related to lived experiences influenced by creativity and consciousness (Hitch et al., 2014).

The construct of being is influenced by and influences a person's social roles and cultural contexts of life (Hitch et al., 2014). Roles provide meaning and occupational engagement to an individual. Roles are meaningful and motivating and help individuals afford self-discovery and development. Culture also influences a person's identity and his or her sense of being, respective to the community and culture in which they live. Social roles and culture influence how people perceive of themselves in relationship to the occupations in which they participate (Hitch et al., 2014).

Becoming is the construct that describes the ongoing process of development, growth, and change that occurs throughout an individual's lifetime (Hitch et al., 2014). It is a process in which goals are set and can evolve as needed to guide occupational engagement. Goals may be set by the individual, but they are often strongly influenced by feedback from others. A person's

goals reflect one's self-concept to improve his or her competence and efficacy. Goals are aimed at improving a person to his or her highest potential, which may or may not be attained over time (Hitch et al., 2014).

Belonging is the interpersonal component of the OPH and describes the connectedness of others in a culture, community, or place (Hitch et al., 2014). It is what makes a person's "life worth living" (Hammell, 2004, p. 302). Wilcock described belonging as the "contextual element of the connectedness of people to each other as they do and of the major place of relationships within health" (2007, p. 5). Reciprocity in relationships is key with negative or positive outcomes with an individual experiencing multiple belongings at the same time (Hitch et al., 2014).

Diffusion of Innovation

The diffusion of innovation is a model used to describe the adoption of new information, ideas, products, or beliefs to change what is currently done or being practiced (Rogers, 2003). The diffusion of innovation uses a bell-curve to represent the various groups identified as innovators, early adopters, early majority, late majority, and laggards to represent their willingness and timelines in the process of change (see Figure 1). Innovators are considered risk-takers who will take the shortest amount of time to adopt change; they are often agents of change and help to recruit others. Early adopters are leaders and often are referred to as trend setters. They are role models who are willing to try the innovation before most. The early majority are also leaders, but they want proven presentations before they are willing to commit to a change completely. The late majority are those who change because of peer pressure; they are cautious and require proof that the change is worthwhile before converting to a new way or idea.

Laggards are apprehensive of innovation and would prefer to continue a status quo rather than change (Kaminski, 2011; Rogers, 2003).

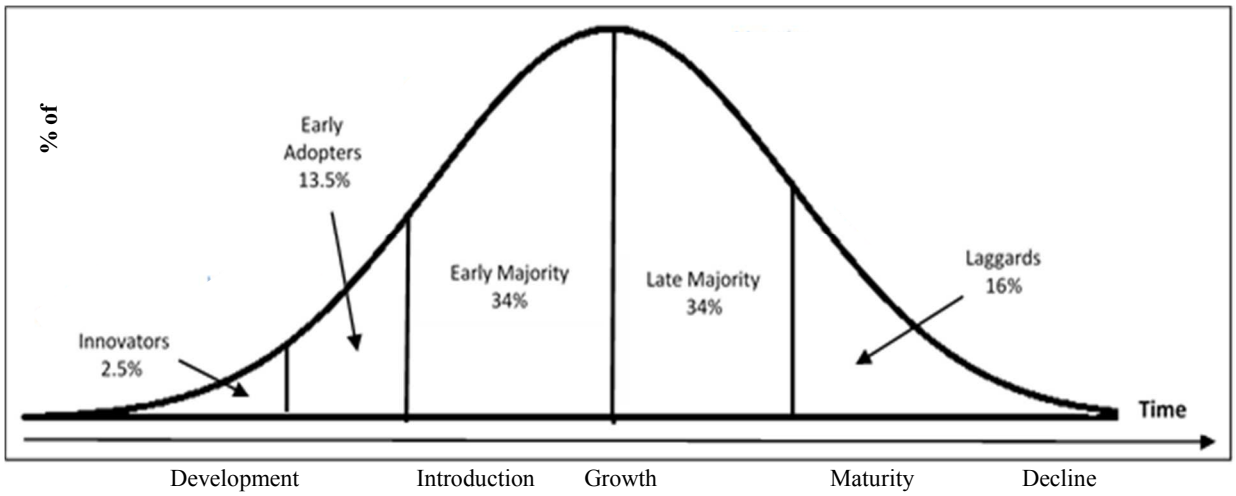

Figure 1: Adopter categorization on the basis on innovativeness. Adapted from *Diffusion of innovations* (5th ed.), by E. Rogers, 2003, New York, NY: Free Press.

According to the diffusion of innovation theory, the process of change occurs through a five-stage adoption process (Kaminski, 2011; Rogers, 2003). The first stage is the knowledge or awareness stage in which a person is exposed to the innovation but does not have all of the information to make a decision to about whether to change. The second stage is the persuasion or interest stage, where the individual gains interest in the idea and seeks further clarification to increase his or her knowledge. The third stage is the decision or evaluation stage. This is where the person begins to apply the innovation mentally to future circumstances. These mental imageries help an individual to determine whether to try the innovation in real life. The fourth stage is the implementation or trial stage, where a person tries to use the innovation in daily practice. The final stage is the confirmation or adoption stage in which the person continues to use the innovation in full (Kaminski, 2011; Rogers, 2003; see Figure 2).

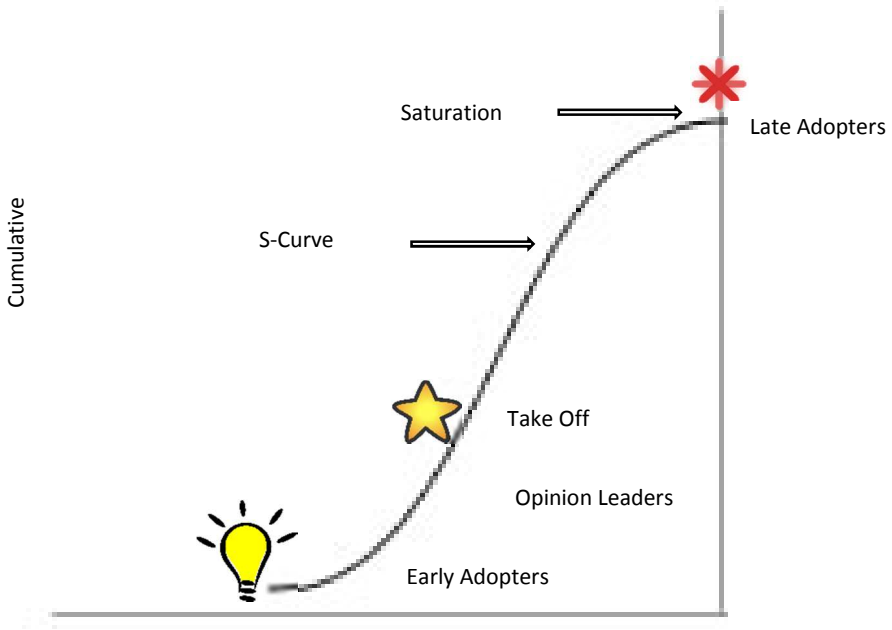

Figure 2. Diffusion of innovation process. Adapted from *Diffusion of innovations* (5th ed.), by E. Rogers, 2003, New York, NY: Free Press.

According to the theory, there are factors that will influence the diffusion, or use of the idea, practice, or object (Rogers, 2003). The characteristics of the innovation, based on the audience's perceptions, can be facilitators or barriers as to how quickly the adoption rate occurs. The following are the characteristics: (a) relative advantage: the degree of how the targeted audience perceives the innovation to be better than the past idea; (b) compatibility: the targeted audience's perception of the innovation's consistency with existing values, past experiences, and the audience's needs; (c) complexity: the perception of how difficult the innovation is to understand and use; (d) trialability: how much an innovation is trialed on a limited basis; and (e) observability: the amount to which the results of an innovation are observable to others. These characteristics help determine whether an innovation will be adopted and used and, if so, how quickly the process will occur (Rogers, 2003).

Applying diffusion of innovation. The diffusion of innovation theory provides a framework to assist researchers to identify characteristics of information that can promote its adoption and use (Sudsawad, 2005). The use of diffusion of innovation throughout the field of occupational therapy is currently limited; however, there are a couple of studies that have used the theory to support the dissemination of knowledge. Sudsawad (2005) used the diffusion of innovation as a framework to discuss the use of evidence-based practice in the field of occupational therapy. Discussion as to making the characteristics of understanding and adopting evidence-based practice appealing and motivating to current practitioners was highlighted as being of most importance. Therapists must see a perceived need and be able to understand the potential use of evidence in daily practice. The author noted that by using a conceptual framework to design, implement, and disseminate innovation, it allows therapists to increase use of evidence-based practice (Sudsawad, 2005).

In 2010, a scoping review was completed to further examine the use of theory to advance the science of knowledge translation, specifically in health care (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010). The researchers found 27 articles used the diffusion of innovation theory to examine how caregivers were using innovation. Of those 27 articles, most of the research was done in the fields of medicine and nursing. However, it is noted in this review that the diffusion of innovation has been recommended for use in the field of occupational therapy for use in knowledge translation. The authors also noted that the diffusion of innovation is considered the gold standard in knowledge translation research and is used as a global reference in studies even if there is no specific theory application (Colquhoun et al., 2010).

In the field of physical therapy, Harting, Rutten, Rutten, and Kremers (2009) used the diffusion of innovation to guide the focus group interviews and the analysis process. The authors aimed to understand physical therapists' use of the guidelines for lower back pain in the Netherlands. The focus group questions were designed to discuss each stage of the process (knowledge, persuasion, decision, implementation, and confirmation) as well as a priori codes used in the content analysis with a directed approach. Through the results and research, the authors noted that while the use of a theoretical model (such as diffusion of innovation) can be challenging to guide research, it is possible and adds value and an advantage over other qualitative studies to determine guidelines or new knowledge applications (Harting, Rutten, Rutten, & Kremers, 2009).

Clemson, Donaldson, Hill, and Day (2014) completed a qualitative research study in which they explored the facilitators and barriers to running an evidence-based home safety fall prevention program in Australia. The researchers completed interviews with occupational therapists and program directors using questions that were guided by the diffusion of innovation. This theory was used to assist the researchers in understanding how practitioners adopted and implemented the fall prevention programs studied. The concepts of relative advantage, complexity, compatibility, and observability were used to provide an a priori outline to complete the analysis of the data. The results indicated that the use of the diffusion of innovation helped to provide a framework for the interviews and to complete thematic coding (Clemson, Donaldson, Hill, & Day, 2014).

While the use of the diffusion of innovation has been limited to the applied health science fields, there is current research that states its use and applicability (Clemson et al., 2014; Colquhoun et al., 2010; Harting et al., 2009; Sudsawad, 2005). By incorporating the diffusion of

innovation, researchers can further analyze the process of change when new information is presented to a group or profession. The concept of occupation-based practice has been presented to the field of occupational therapy; however, the question as to its value and use throughout the field remains debatable. By using the diffusion of innovation to guide the research design, interviews, and a priori coding, this researcher can further assess occupational therapists' understanding, adopting, and implementation of occupation-based practice throughout the profession.

Research Questions

1. How do therapists conceptualize occupation-based practice, and what does it look like to them?
2. What are the constructs that make up occupation-based practice, and how are they interrelated?
3. What are the facilitators and barriers to using occupation-based practice?

Summary

Throughout the past 100 years of the profession of occupational therapy, there have been many changes, areas of growth, and challenges. The profession was founded on the main principles of helping individuals heal through occupation and keeping the mind and body doing to improve function and reintegration into society (Christensen & Haertl, 2014; Reed, 2006). As the profession developed and became better researched and known, the field evolved and has grown into what it is today. The importance of the use of occupation to improve health has been a concept that has waxed and waned over the past 100 years; however, it remains present and at the forefront of the profession (Reed et al., 2013). The focus of the beginning of the 2000s has been to use occupation as part of evaluation, intervention, outcome measures, and fully

incorporated into daily practice (Fisher, 2013). By using the OPH (Wilcock, 2006) and the diffusion of innovation (Rogers, 2003) further insight into practitioners' understanding of occupation and occupation-based practice are anticipated at the study's conclusion. Even with the emphasis that the AOTA has placed on occupation-based practice, there continues to be mixed research on how well, and how much, occupation is engrained in occupational therapy practice throughout the field. Through a grounded theory approach, the above research questions will be further explored to create a theory grounded from the data collected.

Chapter 3: Methodology

A grounded theory design will be used to answer the proposed research questions to generate a theory as it emerges from the data. The rationale, research questions, history and background, aim of the study, sample, settings, gaining access, general steps, human subject considerations, study rigor, strengths and limitations, and timetable for the study will be further discussed in this chapter.

Rationale for Use of Grounded Theory

Glaser and Strauss originally developed grounded theory in 1967 to increase the rigor of qualitative research methods. It was created, specifically, to provide "systematization of the collection, coding, and analysis of qualitative data for the generation of theory" (Glaser & Strauss, 1967, p. 18). While the method has changed and evolved over the past 55 years, the assumptions that reality occurs between people, is always changing, and is an evolution, have remained the same (Richards & Morse, 2013). Grounded theory is a research method used in qualitative research to answer the question: What is going on here? Researchers learn from participants how to comprehend a situation based on participant experiences (Richards & Morse, 2013). Strauss (1987) suggests that when researchers are developing theory, it is an "intimate relationship with the data, with researchers fully aware of themselves as instruments for developing that grounded theory" (p. 6). The goal is for the researcher to develop a theory that generates from the data itself. This researcher argues that there is a need to generate a new theory in regard to occupation-based practice.

Research Questions

This proposed study aims to answer the following research questions.

1. How do therapists conceptualize occupation-based practice, and what does it look like to them?
2. What are the constructs that make up occupation-based practice, and how are they interrelated?
3. What are the facilitators and barriers to using occupation-based practice?

Grounded Theory: History and Background

Grounded theory is a qualitative method of inquiry researchers use to develop theory directly from the gathered data (Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1998). While grounded theory has a systematic process for researchers to follow, it is also flexible in how one gathers and analyzes the data. This method begins with inductive data; however, it encourages investigators to move back and forth between the data and analysis to compare findings and to continue to gather further data until reaching saturation. Grounded theory was initially developed to increase rigor in the qualitative research field and to provide systemization to qualitative research. However, rather than a strict prescription, grounded theory provides general guidelines or principles to follow to formulate a theory. These steps include: (a) writing a research question, (b) participant recruitment and sampling, (c) collection of data, (d) initial coding, (e) focused coding and categorizing, (f) theoretical coding, (g) building of theory, and (h) dissemination of findings. These steps, or guiding principles, allow one to have the direction to complete one's research (Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Grounded theory often includes theoretical sampling (Charmaz, 2014). However, when a researcher is first beginning the data collection process, initial sampling enables the study to have a starting point. Initial sampling guides the research as to where to go with data collection.

Collection criteria are prepared for participants (individuals, groups, or situations) and/or settings with the plan of how to access this type of data. Initial sampling may address the initial research question or represent a specific population. Once this data is collected, a grounded theorist can then move to theoretical sampling where the data can then guide a researcher as to where to move next. Theoretical sampling, in contrast to initial sampling, allows for the expansion of categories found in the initial data collection. It will allow the researchers to conceptualize and theorize through the development of analysis, not improving the ability to generalize. By using memo writing and the initial collected data, a researcher can use abductive reasoning to make inferential leaps as to emerging hypotheses. This procedure allows for the exploration of rationale as to why a phenomenon is occurring from the initial sample. By creating the hypotheses and then gathering others in the sample to try to find explanations, a researcher can create a comprehensive and robust sample until reaching saturation (Charmaz, 2014).

The guidance of the outline of grounded theory does not specify the types of data that a researcher can obtain (Charmaz, 2014). Thus, this is for the researcher to decide based on the aim of the study, the research questions, access to participants, and how he or she can create the most comprehensive picture of the phenomena being studied. Some examples of data that one can collect while following a grounded theory approach include in-depth interviews, observations, and documents (such as field notes, mailed questionnaires, internet surveys, autobiographies, journals, public records, and literature). Any data type is analyzable and coded following its collection and analysis can begin. Coding is the primary means of data analysis. Coding is when salient statements in data are labeled, and it helps to summarize, categorize, or account for all of the collected data. Coding is the primary link between the data and the theory emerging from the researcher's files. Grounded theory has three main types of coding and

includes initial coding, focused coding, and theoretical coding (while the names of coding has changed over the years, the coding formats of Charmaz will be used in this research project.) (Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Initial coding is the first step in the data analysis phase used in grounded theory (Charmaz, 2014). When completing initial coding, researchers should stay as close to the data as possible and should identify information from the data itself, not from the researcher's thoughts or already established codes. It is essential to stay open and to allow the data to be a catalyst for new ideas. These codes are provisional in that they may spark new ideas or the ability to find the need for more data if it is lacks in certain areas. These holes, or gaps, can be found early in the research process, rather than finding the areas of deficit after beginning the analysis or when completing the data collection. Once data derived codes are developed, researchers can move on to the second phase of coding: focused coding (Charmaz, 2014).

Focused coding uses the initial coding and then allows the researcher to sharpen or focus the already established codes with the goal of highlighting the main themes in the data (Charmaz, 2014). During this phase, it is important to analyze, summarize, and conceptualize the data at a larger and broader level to assist in finding the theoretical directions of the data. It is a comparative process in which codes are compared, patterns are sought, the most pertinent information is identified, and any further gaps are identified. While the move from initial coding to focused coding can be described as linear, this is not always the case, and researchers can move between the various types of coding throughout the analysis process. No matter which phase of coding, it is important that when using grounded theory, themes emerge from that data rather than from one's preconceived ideas or codes. Theoretical coding is the final step of

analysis in grounded theory and enables a comprehensive and coherent exploration of theory (Charmaz, 2014).

The final phase of coding, theoretical coding, differs from the first two in that it is not truly emerging from the data (Charmaz, 2014). The main reason for using theoretical codes is to create a theory from the focused codes. The focused codes are integrative and create a story of a researcher's analysis of the collected data. While analyzing the data and creating a theory, the researcher must be aware of preconceptions, and in turn, avoid them when in this final phase. Preconceptions can be difficult to avoid; however, it is important to return to the gathered data to make sure concepts are truly from the data and not from the researcher's bias. One way to avoid this occurrence is through memo writing (Charmaz, 2014).

Memo writing is used throughout the research process with grounded theory to advance analysis, increase efficiency and the organization of the developing theory, and assist in the creation of theoretical categories (Charmaz, 2014). When using memo writing, codes can be analyzed early in the analysis process and assist in identifying the direction to pursue in theory building. Memos can consist of questions that may arise, collected data, coding, ideas, or speculations that may occur at any time throughout the research process. This iterative process can also assist in critical reflexivity. While there are no specific guidelines to follow with grounded theory, the methodology does encourage researchers to follow the research using an analytic mindset as the study progresses (Charmaz, 2014).

In qualitative research, it can be difficult to determine when saturation has been reached (Charmaz, 2014). Saturation is when no other categories or properties can be found in any additional data collected (Glaser & Struass, 1967). Determining a point of saturation is dependent on the research study. Thus, a grounded theorist should continue to gather data until

each of the theoretical categories (of the emerging theory) is robust, and no new categories have emerged (Charmaz, 2014). Saturation, is defined as when no further prominent categories have emerged from the data. Theoretical sampling saturation is the goal of researchers and can be done by maximizing differences between groups (Glaser & Strauss, 1967). Once saturation has been achieved, the researcher can establish insightful patterns from the data that will, in turn, help to create abstract theoretical relationships (Charmaz, 2014).

Throughout the data collection and analysis process, grounded theorists will sort or organize data to help create or refine the theory that is emerging from the data (Charmaz, 2014). Sorting helps integrate categories found in the data, and comparisons can begin at an abstract level. Because of the abstract nature of sorting, researchers may also want to use diagramming to provide a more distinct and concrete image of ideas or emerging relationships. The use of memos may also be helpful in the process of constructing a theory. Through this process, theory construction is the final step of the grounded theory process (Charmaz, 2014).

Methodology: Applied

The purpose, structure, and principles of the grounded theory approach, as stated above, allowed this study to employ a grounded theory approach. By using this methodological approach, this study will provide a better understanding of occupation-based therapy practice.

Participants

A purposeful sample was used in this study to analyze a broad and rich data set. A purposeful sample is used to choose participants who will provide information-rich data to study in-depth (Benoot, Hannes, & Bilsen, 2016). These cases are used to learn a great deal of information about a central issue or the purpose of the research project, thus the term purposeful sampling (Patton, 2002, as cited by Benoot et al., 2016). This research study used purposeful

sampling techniques, including convenience sampling (those that this researcher will have easy access to and with no additional funds). To reach saturation, one participant was asked if she knew other therapists who would be willing to contribute to the study by participating in a focus group. This participant reached out to colleagues and assisted with finding individuals for the focus group (snowball sampling; Benoot et al., 2016).

Licensed occupational therapists were the sample for this study. The inclusion criteria included having passed the national board exam, a minimum of 3 years of clinical experience, and full-time employment (as defined by the employer). Practitioners were chosen based on specific settings to further analyze occupation-based practice throughout the field of occupational therapy, including therapists who worked with pediatrics and adults and who provided services in home care or in-patient rehabilitation. The participants were all chosen from the northern Connecticut and western Massachusetts region, as practice varies throughout geographic regions of the country. Such differences could be because of the variances in academic programs, payer sources, and the culture of the communities throughout the United States. By narrowing the geographic area, one can limit the external forces that may impact a study and achieve a greater depth of inquiry (Glaser & Strauss, 1967).

Through the course of the study, the researcher used theoretical sampling to select participants who added further insight to the already gathered data (Glaser & Strauss, 1967). Theoretical sampling provided this researcher the ability to identify gaps in the emerging theory to select the remaining participants (Glaser & Strauss, 1967). Recruitment occurred via the American International College fieldwork educator database and then through snowball sampling just for the participants for the focus group. These fieldwork educators may also be found in other educational institutions' databases and are not solely associated with American

International College. Once occupational therapists were identified through purposeful sampling, an e-mail (see Appendix A) to the prospective participant was sent. This e-mail included an explanation of the study and its purpose and the consent form. E-mails were only sent to occupational therapists who met all of the inclusion criteria. Prior to any form of data collection (in-depth interviews, focus group, or photographs gathered) the researcher obtained the consent form (see Appendix B) and demographic questionnaire (see Appendix C) from each participant.

Setting

Interviews and focus groups all occurred in a quiet room or space and were in a location that was convenient and comfortable for the participants. As each practitioner was from a different workplace, the researcher made the interview and focus group sites as convenient and comfortable as possible. For interviews, each participant was given the choice of where he or she would be most comfortable. When the participants were unsure as to a location, suggestions were provided to such places as a quiet room at a local library, a coffee shop, or the college at which the researcher works. The participants chose locations such as their homes, workplaces, the researcher's workplace, and an online video conferencing platform. All interviews were recorded, transcribed, and uploaded into NVivo software for all coding and analysis.

Gaining Access

The participants were identified by personal contacts and the use of the American International College fieldwork educator database. By using purposeful sampling, this researcher identified potential participants that work throughout the health care continuum. However, to coordinate the focus group, snowball sampling was used to identify other contacts that the researcher used in the one focus group. The researcher made initial contact via e-mail after identifying each participant. All of the participants received the participant recruitment e-mail

(see Appendix A) and consent form (see Appendix B) from the primary researcher. After agreement and consent, data collection methods were scheduled.

General Steps

1. Reached out to potential participants.
2. Obtained informed consent from each participant prior to any data collection.
3. Data collection:
    a. Demographic questionnaires
    b. In-depth interviews
    c. Focus group
    d. Photovoice (unable to obtain, will be further explained)
4. Data analysis using grounded theory approach (occurred simultaneously to data collection) using NVivo.
5. Completion of data collection once saturation was reached.
6. Compiled all occupational therapist participant demographics.
7. Theory emergence.

As previously described, the participants were identified via the American International College fieldwork educator database. After the researchers sent an initial e-mail and obtained informed consent, each participant completed a demographic questionnaire (see Appendix C) and an in-depth interview with the primary researcher. This in-depth semi-structured interview (see Appendix D) took place in person or via an online video conferencing platform (based on the participants' preferences). One focus group (see Appendix E) also occurred toward the end of the data collection phase with participants who were not interviewed and who were identified through purposeful and snowball sampling. The intention of this focus group was to provide

practitioners the opportunity to interact with one another to generate a comprehensive discussion and provide the researcher with richer descriptions.

Following these steps, the researcher offered an invitation to key informants to encourage participation in the photovoice phase of the study. Key informant identification took place during the interview and focus group phases using purposeful sampling and was intended to enhance the theory further. These participants were identified by their use and adopters of occupation-based practice. They had a clear understanding of and value for occupation-based practice as communicated during the in-depth interviews. Those participants identified as key informants were asked to take pictures over a week's duration of what occupation-based practice looks like in practice (see Appendix F- Photovoice instructions) and a follow-up meeting was intended to be scheduled to discuss the photograph(s). The instructions included that the therapists should not include any confidential information about clients, such as no pictures of a client's face or personal property with any personally identifying information (i.e., date of birth, name of facility, etc.). Those therapists who were asked to take photographs when they saw or used occupation-based practice would have sent the photographs to the primary researcher using a password-protected e-mail that was designated only to gather information regarding this study. Follow-up interviews (see Appendix G) would have used an online conference platform with the picture posted on the screen throughout the interview. Each interview and focus group would have been recorded and transcribed verbatim.

Unfortunately, the photovoice component of this study was not completed as planned. Four of the participants were asked to participate in this portion of the study; however, because of workplace rules and regulations, no one was able to take pictures. Each participant reported

that he or she spoke to his or her supervisor, and in one instance to the owner of the company, and were told that it was a violation of company policy.

Throughout data collection, all transcriptions were typed in a Word document and then uploaded into NVivo qualitative data analysis software, and a grounded theory approach was used to complete data analysis. Once saturation was reached, sampling and data collection ceased and any remaining data analysis was continued until completion. The goal of data analysis was to create a theory or methodology in which occupation-based practice is further described to build on ways to measure its use by individuals, programs, organizations, and/or the profession.

Human Subject Considerations

After this research study was approved by the dissertation committee, it was submitted to the IRB at American International College. After approval was obtained, it was sent to Nova Southeastern University's IRB. After review and approval from the IRB, the study was completed as it is outlined. There were in-depth interviews and a focus group. Each participant was sent an initial e-mail invitation to participate in the study and a second email with an in-depth description of the study and its purpose. The e-mail included the informed consent, which was then collected prior to any data collection. All data were kept confidential and the transcribed interviews, focus group, field notes, or memos were stored within NVivo and on the researcher's locked password-protected laptop with a backup on an encrypted flash drive that was stored in the researcher's locked office in a locked desk (to which only the researcher has a key) at her place of employment. Any recordings were removed from the recording device (after transcription) and stored on the researcher's password-protected laptop and imported into NVivo as well. Within NVivo, the data was also password-protected on a locked laptop and a file within

the NVivo program. The research study was not changed or compromised so there was no need for an IRB addendum; thus, none of the participants needed to be notified via e-mail with another informed consent.

Study Rigor

When conducting qualitative research, it is imperative that a researcher practice reflexivity (Charmaz, 2014; Creswell & Poth, 2018). By acknowledging one's background, how that impacts his or her interpretation data, and what he or she may gain from the research, a grounded theorist is allowing for transparency or reflexivity. Researchers are identifying their interests, positions or beliefs, and/or assumptions that may directly influence the research (Charmaz, 2014). It is best practice for a researcher to self-situate and be upfront with potential consumers of the research conducted (Charmaz, 2014; Creswell & Poth, 2018).

As the primary researcher on this study, it is important to identify that I am a trained, licensed occupational therapist who has a master's degree in occupational therapy and who teaches full time at American International College while also practicing in both early intervention and skilled nursing facilities. I am currently a PhD candidate. My current research interests include occupation-based practice, assistive technology, and educational research for higher education. I have a strong belief that occupation should be at the center of what occupational therapists do with clients daily. The completion of a research journal throughout the process (data collection, analysis, and interpretation) allowed me to view the lens on how my personal beliefs impacted the process and how I understood each step.

The subject of quality is mixed in the literature, especially on how reliable and valid qualitative research is and we determine its significance (Krefting, 1991; Rolfe, 2006; Sandelowski & Barroso, 2002). However, over the past 30 years, there has been increased

discussion and published literature regarding the components of trustworthiness and criteria to evaluate qualitative research. The categories of credibility, dependability, transferability, and confirmability have been defined and used to evaluate qualitative research rigor. Credibility, or accuracy, of the data can be enhanced by increased time in the field, the use of various types of data sources, researcher reflexivity, the use of member checks, peer review, creating a rapport between the researcher and participants, and triangulation. Dependability is the stability and ability to track changes or conditions over time, which, in turn, allows for consistency of findings. To increase the dependability of a qualitative study, a researcher can complete triangulation, peer checks for coding, audit trails, documentation of all raw data, and assessment of the research methods used for data analysis. Transferability is whether the findings can be applied to other situations or persons elsewhere. When conducting qualitative research, it is okay to state that the findings will be descriptive in nature rather than generalizable. To determine if a study is transferable, the researcher(s) must provide enough detail for the consumer to determine if generalizability is even possible. Finally, confirmability is the objectivity of the data, and can be evaluated based on researcher agreement of coding and data analysis, often including an audit trail to have researchers explicitly state personal biases and its effects on the research. The use of the audit trail, triangulation, and researcher reflexivity is imperative to determine confirmability of a qualitative research study (Krefting, 1991; Rolfe, 2006; Sandelowski & Barroso, 2002).

This research study used multiple methods or strategies to establish trustworthiness. When completing this study, triangulation was used throughout the process. The first type of triangulation used was gathering multiple types of data sources (Denzin, 1978; Krefting, 1991; Patton 1999). In-depth interviews and a focus group were conducted, and all data sources were analyzed. Another source of triangulation included multiple settings in which the occupational

therapists work to analyze consistency throughout the continuum of health care. The researcher also had participants enter the research process at several points (multiple points of entry) with the guideline of using initial sampling to identify preliminary participants, and then theoretical sampling to examine constructs identified by the initial sample. Member checks were also completed with five of the participants after data analysis was completed. Each was provided the description of the three themes and asked for agreement and/or feedback as to whether they felt their interviews/focus group was misrepresented in the findings. All five reported that the themes were congruent with his or her thoughts shared during the data collection process. Finally, triangulation of analysis occurred with the researcher completing the coding and then the chairperson of the researcher's dissertation committee coded segments of the data with comparison of findings. By using triangulation, the credibility, dependability, and confirmability of the study will be enhanced (Denzin, 1978; Krefting, 1991; Patton 1999).

To address credibility and confirmability, the researcher used reflexivity throughout the research process (Charmaz, 2014; Krefting, 1991). Field notes and memos were completed throughout the data collection and analysis processes and were uploaded and stored within the NVivo software. This allowed the researcher to identify bias and personal feelings and to track the research process. Finally, this study is descriptive in nature and will not make any claims of generalizations or transferability. However, demographic data that was collected will be compared and discussed in the study results (Charmaz, 2014; Krefting, 1991).

This research study used multiple strategies to assist in the establishment of trustworthiness throughout the study to increase the rigor of the qualitative grounded theory research study. While everything will be done to ensure the highest level of rigor, there will be both strengths and limitations of this study.

Strengths and Limitations

Grounded theory is a well-known and acknowledged methodology within the qualitative research realm. The methodology addresses questions like, What is going on here? and Is it able to be used by many different disciplines? With each type of methodology comes advantages and disadvantages; grounded theory is no different. The strengths of grounded theory include: (a) its intuitive appeal, (b) that it is fostering creativity, (c) its potential to conceptualize, (d) its data analysis systems, and (e) that it produces rich data (Hussein, Hirst, Salyers, & Osuji, 2014). Weaknesses, or limitations, of grounded theory include: (a) it is an exhaustive process, (b) that methodological errors are possible, (c) the difficulty of doing literature reviews and not creating assumptions, (d) that there are multiple approaches or schools of thought, and (e) that it is not generalizable (Hussein et al., 2014).

The intuitive appeal of grounded theory allows researchers to treat data within provided guidelines by immersing themselves in the data (Charmaz, 2014; Glaser & Strauss, 1967; Hussein et al., 2014). It is logical and allows novice researchers to follow the process by getting started, doing the research, and then completing the project in a pragmatic way. Grounded theory also allows researchers to be creative with research with no use of a priori knowledge or hypotheses. The researcher can develop theories directly from the data in a natural system rather than having multiple biases and prior assumptions. Another strength is that there is the possibility to conceptualize new concepts or constructs by constantly comparing the data through the writing of memos. This qualitative method is different than the others in that a theory is developed based on the data collected. Grounded theory also provides researchers with a systematic approach on how to collect data, analyze data, determine saturation, and the possible ways to disseminate findings. It also is strategically designed to have triangulation to improve

rigor through the constant comparative logic and coinciding process of collecting and analyzing data. Finally, grounded theorists collect rich data that is full of depth. This advantage allows researchers to create categories to compare, which, in turn, helps to develop new ideas and theories (Charmaz, 2014; Glaser & Strauss, 1967; Hussein et al., 2014).

While the grounded theory approach has many strengths, it also has some limitations that researchers need to understand before using this methodology. The first disadvantage is that it is an exhaustive process that requires significant time, effort, and, in some cases, money (Hussein et al., 2014). It can be taxing to conduct the data analysis, and researchers must make sure that they do not lose sight of the study's purpose (Hussein et al., 2014). Another limitation is that there is an increased chance of methodological errors. Some of the most common errors include the confusion and blurring of theoretical and purposeful sampling and only using one data type or source (i.e., in-depth interviews only; Glaser & Strauss, 1967; Hussein et al., 2014). The methodology is controversial because if a researcher should complete a literature review prior to the study, or after, it has the potential to create bias and assumptions (Glaser & Strauss, 1967), while others argue that a literature review must be completed in order to achieve rigor. However, researchers must remain sensitive to the data and bracket known assumptions or biases (Hussein et al., 2014). Since the initial publication of grounded theory by Glaser and Strauss (1967), at least four other forms of the method of inquiry were developed, causing increased confusion and difficulty for researchers (Hussein et al., 2014). Thus, it is essential for researchers to operationally define the type of grounded theory and which exact assumptions and procedures they will follow. Finally, the ability to generalize the findings of grounded theory research is limited due to small samples because it is more explorative than explanatory and because it is difficult to replicate theories (Hussein et al., 2014).

While the method of inquiry has strengths and limitations, those specific to this study were difficult to predict prior to any data collection or analysis. However, prior to the study being completed, the noted strengths were that the primary researcher is a licensed and registered occupational therapist with 10 years of practice experience. The research question is clear, simple, and is appropriate for a grounded theory study. The rigor of the study was also well thought out and planned to increase trustworthiness with such strategies as triangulation, an audit trail, and reflexivity, and was peer-reviewed throughout the entire study. While there are many strengths identified, there were also some limitations. The first limitation is that all of the participants were from a small geographic location of the United States (Connecticut and western Massachusetts); thus, is difficult to generalize the findings to the entire field of occupational therapy. Another limitation, according to Glaser and Strauss (1967) is that the literature review was completed prior to any data collection or analysis, as the review was required for the approval of the study. All possible measures were taken to have the highest rigor possible at the completion of the study.

Summary

"Occupational therapy, at its best, acknowledges the power of engagement in occupation" (Law, 2002, p. 646). From the beginning of our profession, it has been a foundational belief that occupation is crucial to helping clients return to their normalcy. This definition of independence and successful completion of occupations should be provided by the client. Occupation-based practice has been defined in various ways, however, the three most common include: (a) the use of meaningful occupation as an intervention to promote positive outcomes from the therapy process; (b) the process of helping a client live a meaningful, successful, and productive life; and

(c) the process of facilitating a client to have a life that is successful and meaningful with the social world in which they live (Price & Miner, 2007).

Occupations provide personal and cultural meaning; are affected by context; change over time; influence identity, health, quality of life, and relationships; and require adaptation (AOTA, 2014b; Price & Miner, 2007). Occupational therapists must determine what occupations are meaningful to clients and then use these occupations during the intervention phase of treatment in order to increase a client's performance, independence, health, well-being, and quality of life to provide occupation-centered services (AOTA, 2014b; Moyers, 2005). It is important to emphasize that occupation-based practice is not only using occupation as an intervention in a natural setting, but rather an interface between therapeutic relationships, the therapeutic process, and various types of interventions **(**Price & Miner, 2007).

By completing this study, this researcher now further understands what therapists conceptualize occupation-based practice to be, what it looks like to them, what the constructs are that make up occupation-based practice, and what the relationships are between those constructs. With the reinforcement of the AOTA to make occupation-centered care at the forefront of practice, it is important to understand practitioners' support, belief, use, and understanding of occupation-based practice. With the lack of current research on this topic, this study will further enhance the professions' body of knowledge with the anticipation to increase the diffusion of occupational-centered practice throughout the field of occupational therapy.

Chapter 4: Findings

Through this study, the primary researcher answered the research questions: (a) How do therapists conceptualize occupation-based practice, and what does it look like? (b) What are the constructs of occupation-based practice, and how do they relate? and (c) What are the facilitators and barriers to using occupation-based practice? This study used a grounded theory approach to further assess occupational therapists' understanding and use of occupation-based practice. The findings will be further discussed below.

The data revealed that occupational therapy practitioners perceive occupation-based practice through the following themes: (a) facilitating doing, being, and becoming; (b) the profession's identity; and (c) facilitators and barriers to the use of occupation-based practice. The remainder of this chapter will discuss the themes that emerged in the study and present a new developing theory of the dynamic process of occupation-based practice.

Demographic Information

Eight out of the 10 participants completed the demographic questionnaire. Two of the participants received two follow-up e-mails and completed the focus group, but they did not complete the questionnaire. After the follow-up e-mails, neither participant completed the questionnaire; thus, their demographic data is not included in the demographic information. The researcher was able to determine participant gender during the face-to-face interviews and focus groups via in-person meetings or video conferencing and included that demographic parameter in Table 1.

Table 1

Participant Demographic Information

	Male	Female
Gender	1	9
Self-Identified Ethnicity		
White/Caucasian	1	6
Hispanic	0	1
Highest Earned Degree		
Bachelor's	1	1
Master's	0	6

The participants' ages ranged from 28 years to 42 years of age, with a mean of 34 years of age. Each participant in the study passed his or her NBCOT board certification exam in the past 2 to 18 years with an average of 9 years since passing the exam. Each participant reported that he or she has practiced as an occupational therapist from one and a half years to 18 years with a mean of five and a half years of experience. One participant who passed the NBCOT exam 18 years ago reported only practicing for seven and a half years due to serving in the military for just over 11 years. The participants currently practice in the following types of settings: the school system (two), adult subacute rehabilitation (four), adult home care (two), and geriatric home care (one). The researcher asked the participants about prior settings in which they have worked, and responses included practice areas such as school systems, pediatric outpatient, adult acute care, adult subacute care, adult and geriatric home care, geriatric mental health, and army mental health.

While the researcher was not attempting to acquire a representative sample of the overall occupational therapy population, in many ways the sample resembles the demographics of the profession. The AOTA (2015) conducted a workforce and salary survey that revealed that 93% of occupational therapists were female. This study's participants were 90% women. The AOTA survey also showed an average of 9 years of experience for occupational therapists, and this study's participants had five and half years of experience. The AOTA survey also noted that 60% of occupational therapists had a graduate degree, and the other 40% had a baccalaureate or doctoral degree. Seventy-five percent of the participants in this study had a graduate degree, and 25% had a baccalaureate. The workforce survey identified that most of the practitioners worked in hospitals (26.6%), schools (19.9%), long-term care facilities/skilled nursing facilities (19.2%), out-patient centers (10.7%), and home health (6.8%). The use of purposeful sampling for this study did not yield a representative sample in terms of work settings with participants working in home health (20%), rehabilitation hospitals (60%), and the remainder in schools (20%). Only one of the participants (of the eight who completed the demographic survey) identified as being Hispanic (12.5%), versus the 3.2% who identified as being Hispanic in the overall workforce survey (AOTA, 2015). While the goal of this study was not to provide a representative sample, the sample included a close representation of the current composition of professionals.

Coding Process

The interviews and the focus group were recorded with a digital voice recorder, and the recordings were then uploaded into Express Scripts to assist in transcription. The researcher transcribed all data sources in Microsoft Word and then imported transcript files into NVivo for data analysis. The completion of initial coding began by using line-by-line coding for all data sources. There were numerous nodes as concepts and sentiments identified because of using line-

by-line coding (titled as closely to the data as possible). The line-by-line coding generated a large number of nodes (72), which were similar to the point of redundancy and were later combined in the second phase of coding (focused coding) into categories (15). The process of combining initial nodes into the set categories varied based on the content each node included. Each category will be further discussed below with descriptions of the associated categories. After initial coding, focused coding, theoretical coding, and meeting saturation, the researcher identified theoretical statements from the data. A discussion of the audit trail and coding process is below.

Nodes to Categories to Development of Facilitation Doing, Being, and Becoming

The most extensive grouping of concepts ultimately emerged as the theme of facilitating doing, being, and becoming. Data categories that comprised this theme included clinical reasoning, therapeutic use of self, and use of occupations—doing, goals, grading and adapting, client meaning, and assessment/evaluation. The formed category included a reduction of nodes representing consistency in concepts. The process of data transformation from nodes to categories, and the theme facilitating doing, being, and becoming is represented in Figure 3 and further described below as the evolution of category and theme development.

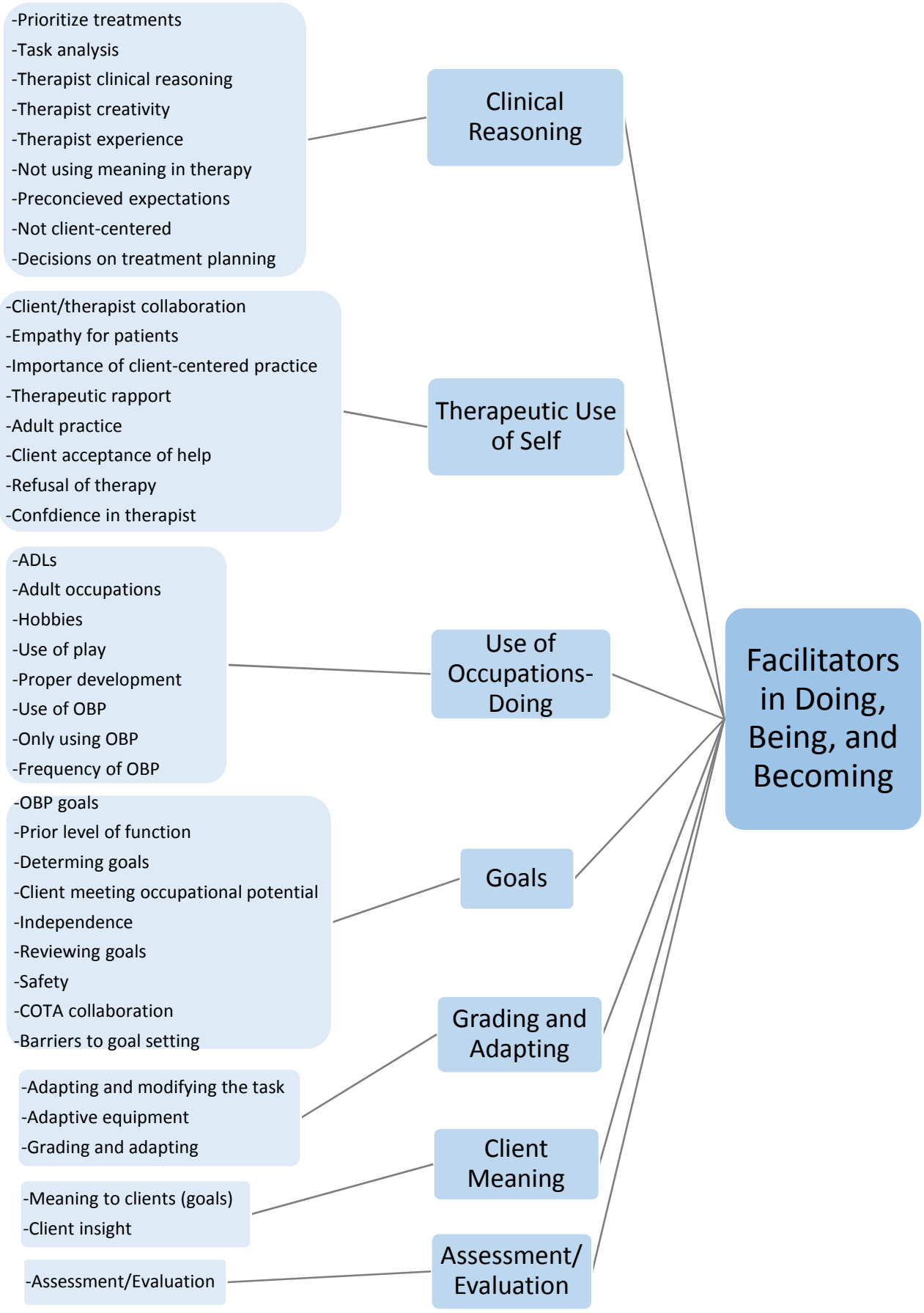
Facilitators in Doing, Being, and Becoming
Clinical Reasoning
-Prioritize treatments
-Task analysis
-Therapist clinical reasoning
-Therapist creativity
-Therapist experience
-Not using meaning in therapy
-Preconcieved expectations
-Not client-centered
-Decisions on treatment planning
Therapeutic Use of Self
-Client/therapist collaboration
-Empathy for patients
-Importance of client-centered practice
-Therapeutic rapport
-Adult practice
-Client acceptance of help
-Refusal of therapy
-Confdience in therapist
Use of Occupations-Doing
-ADLs
-Adult occupations
-Hobbies
-Use of play
-Proper development
-Use of OBP
-Only using OBP
-Frequency of OBP
Goals
-OBP goals
-Prior level of function
-Determing goals
-Client meeting occupational potential
-Independence
-Reviewing goals
-Safety
-COTA collaboration
-Barriers to goal setting
Grading and Adapting
-Adapting and modifying the task
-Adaptive equipment
-Grading and adapting
Client Meaning
-Meaning to clients (goals)
-Client insight
Assessment/ Evaluation
-Assessment/Evaluation

Figure 3. Audit trail of facilitating doing, being, and becoming.

Clinical Reasoning

The category of clinical reasoning is comprised of concepts representing the decision-making process required by therapists for prioritizing treatments and overall treatment planning. The therapists also described their creativity, years of experience, and task analysis skills when working with clients. Multiple participants highlighted the importance of using client-centered practice and making sure interventions were meaningful to the clients with whom they worked. The combining of nine nodes into this category occurred because all of the required components of therapist clinical reasoning skills during each or all the phases of the occupational therapy process.

Therapeutic Use of Self

The therapists who participated in this study described the client and therapist collaboration and the importance of creating client-centered care. Multiple participants discussed how therapeutic rapport was especially important if clients accepted help. These nodes were then combined, as they all described their personality and perceptions to encourage a client to engage in the therapeutic process.

Use of Occupation-Doing

The therapists shared experiences about their current use of occupation-based practice, and all of the participants described a variety of interventions, including ADLs, play, hobbies, and other occupations in which clients engage. The therapists described using occupation in practice, only using occupation-based practice, and the frequency of how often they used occupation-based practice. Multiple statements were made by the therapists that identified occupation as a primary means of intervention. All nodes in this category described occupation

as the primary medium of treatment to improve a client's impairments for the goal of increasing client outcomes.

Goals

Multiple nodes emerged from the data when analyzing each interview and focus group that revolved around goal-setting. Specifically, the therapists determined goals using the client's prior level of function and goal of independence to help guide the goal setting process. The therapists also looked at safety and collaboration with occupational therapy assistants in goal setting and the review processes. The nine nodes combined into the category of goals all described how therapists determine goals, when the client has met his or her goals, and the review of goals.

Grading and Adapting

The therapists discussed various ways they adapted and modified treatment sessions, items for use, or new adaptive equipment. Other nodes regarding environmental modifications emerged from the data with the goal of the three nodes to increase client independence. Thus, creating this category occurred because all of the nodes describing how therapists modify or adapt treatment for clients, their use of adaptive equipment, environmental adaptations, or modifying/adapting the task.

Client Meaning

The two initial nodes that were in this category both described what is important and meaningful to the client (with a primary focus on goal setting and interventions) to have the best possible occupational outcomes. While there were not multiple nodes, all statements coded for meaning to clients focused on the importance of client-centered therapy and that client participation is greater when it is meaningful to them.

Assessment and Evaluation

This one node was not combined with any others and was identified as a primary category. The primary category of assessment and evaluation identified one of the most important phases of the occupational therapy process. All of these coded sections of the data defined how a therapist's use of evaluation skills determined client baseline, progress, and goal achievement.

Nodes to Categories to Development of Professional Identity Confusion

The next grouping of concepts evolved as the theme of professional identity. Data categories that comprised this theme included a narrative explanation of occupational therapy and defining occupation. A reduction of each category of nodes represented consistency in concepts. The process of data transformation from nodes to categories, and finally, the theme of professional identity is represented in Figure 4 and further described below as the evolution of category and theme development.

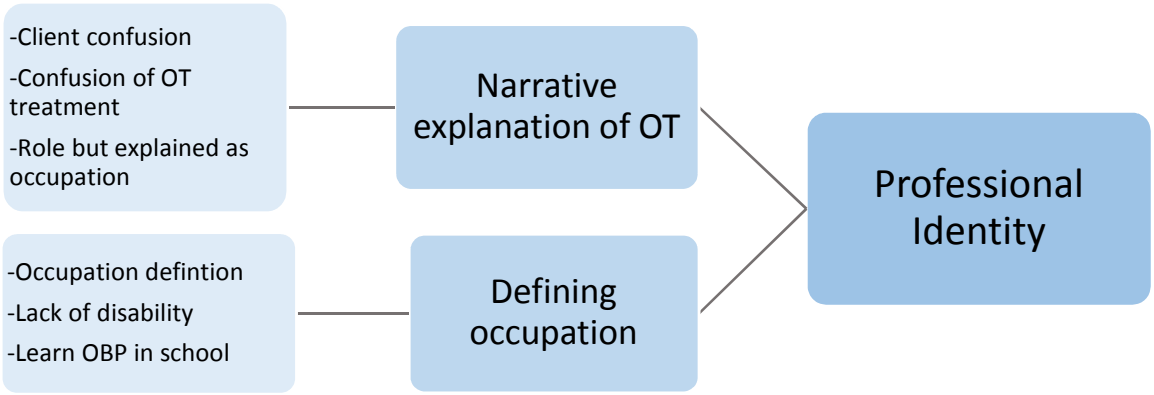

Figure 4. Audit trail of the profession's identity.

Explanation of Occupational Therapy (A Narrative)

The researcher combined these nodes into the category of an explanation of occupational therapy category with a strong emphasis on therapists having difficulty with their own identity and the profession's ability to define and describe occupational therapy clearly. The participants provided examples of client misunderstanding or not understanding the purpose of occupational therapy services, which often resulted in a lack of confidence and/or refusal of services.

Defining Occupation

The participants defined occupation and provided their perceptions or opinions about how they incorporated occupation-based practice into treatment sessions. The representation of multiple nodes formed the category in which the participants had described and defined occupation.

Nodes to Categories to Development of Facilitators and Barriers of Use of Occupation-Based Practice

The final group of concepts collectively emerged as the theme of facilitators and barriers to use of occupation-based practice. Data categories that comprised this theme included practice settings, barriers to use of occupation-based practice, diffusion of innovation, facilitators to use

of occupation-based practice, and medical model. Each category was formed by a reduction of nodes representing consistency in concepts. The process of data transformation from nodes to categories, and finally, the theme facilitators and barriers to use of occupation-based practice is represented in Figure 5 and further described below as the evolution of category and theme development.

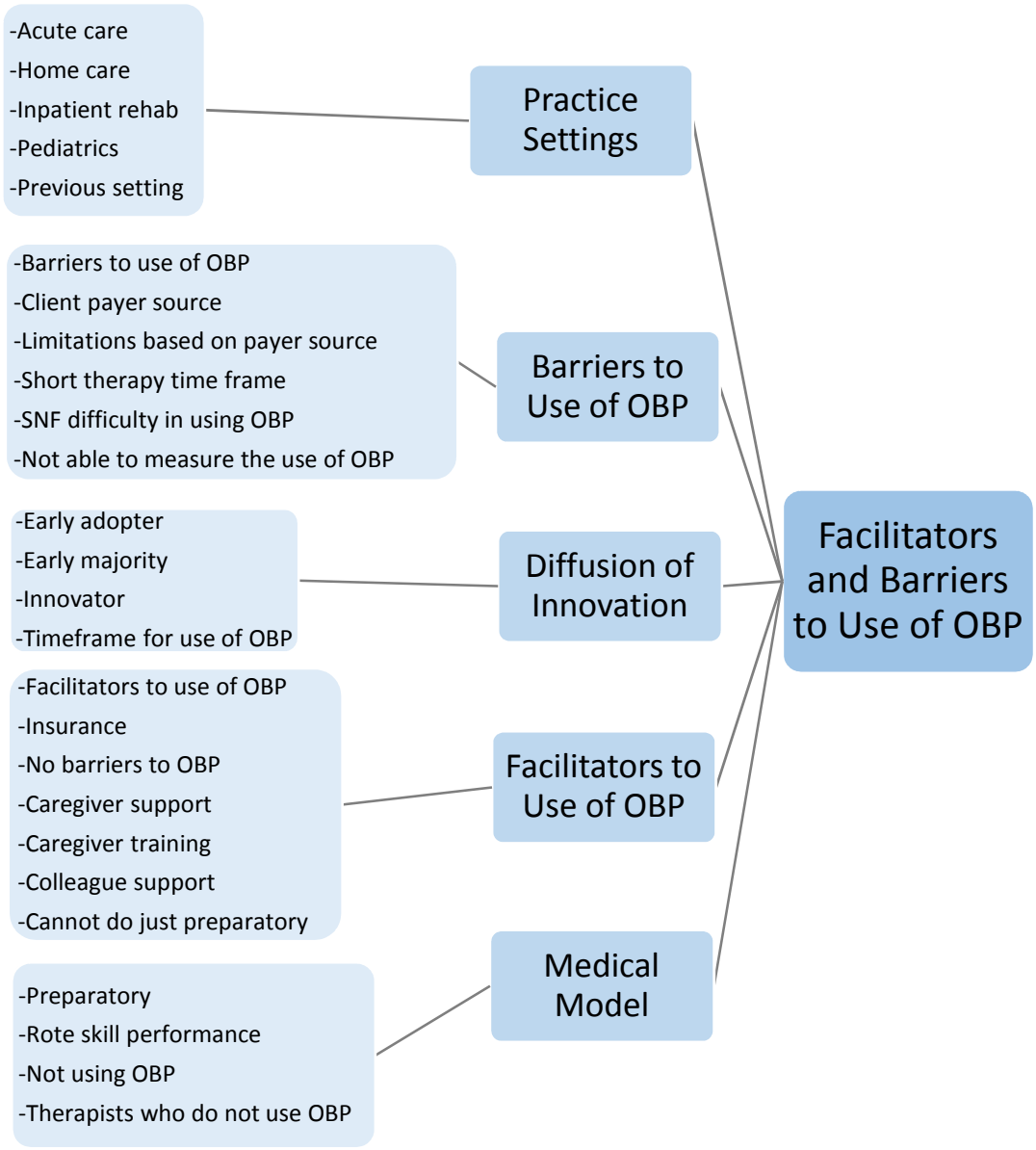

Figure 5. Audit trail of facilitators and barriers to use of OBP.

Practice Settings

This category represents the settings in which therapists provided occupational therapy services. The participants currently worked in adult rehabilitation, home care (with the adult and geriatric populations), and school systems, which resulted in influencers to their use of occupation-based practice. The researcher combined all settings due to the research questions not focusing on each setting separately.

Barriers to the Use of Occupation-Based Practice

During the initial round of coding, the researcher combined all the nodes that indicated the reasons why therapists were unable to use or had difficulty using occupation-based practice. The participants discussed such reasons as insurance, systems in place at their workplace, lack of resources, and lack of support. This category depicts the range of factors identified by the participants as barriers to using occupation-based practice, which was constant, regardless of the practice context.

Diffusion of Innovation

As part of the theoretical basis of this research study, the researcher used the diffusion of innovation to explore further the position of where therapists landed on the continuum of adoption about using occupation-based practice. These nodes were categories the therapists self-identified as to where they were on the diffusion of innovation curve as to their initial use of occupation-based practice.

Facilitators to the Use of Occupation-Based Practice

These nodes from the initial coding all were reasons as to why therapists could use or found it easier to use occupation-based practice. Some of the stated facilitators were flexibility in scheduling, multiple materials and resources, focus of care was occupation-based, and being creative in treatment planning. These nodes were all combined into the category of facilitators to the use of occupation-based practice.

Medical Model

These nodes were interventions that "prepare" a client for occupation-based practice. The participants described these treatments as those that often would not be doing an activity or occupation at all (i.e., modalities, strengthening). While many of these interventions described

were preparatory in nature, all aligned with the medical model, and not an occupation-based model.

Findings

After the completion of initial and focused coding, the researcher further examined the categories, and three main themes emerged: (a) facilitating doing, being, and becoming; (b) professional identity; and (c) facilitators and barriers to use of occupation-based practice.

Facilitating Doing, Being, and Becoming

Facilitating doing, being, and becoming is one of the themes that emerged from the data and focused on the occupational therapy process. Wilcocks' model of OPH (2016) provided the name for this theme. The "doing" is how occupational therapists do their jobs as therapists with each client. This includes the use of occupation-based practice with clients. The "being" is how the therapists feel about what they are doing with their clients. The "belonging" is the meaning and purpose of why therapists and their clients choose the occupations and interventions in which they participate. This theme provides a rich description of how therapists can facilitate the therapy process with the use of occupation-based practice with clients to provide meaning and purpose to the clients.

As occupational therapists, the participants identified multiple areas of the therapeutic process that are important in this theme. These included such skills as clinical reasoning, therapeutic use of self, assessment and evaluation, grading and adapting, goal setting, review, and achievement.

Clinical reasoning. The therapists articulated that they had to use clinical reasoning regardless of the setting in which they worked and had to use creativity and prioritize

intervention sessions. One therapist expressed that "I have to be super savvy." She also provided an example of how she can be creative and turn any object into an intervention for a child:

> I can walk into a room with a thing of tape and headphones, and I can make an activity out of it. But it's only because I have been doing it for 18 years, and I have always been analyzing, always analyzing, always analyzing how I can make this (picks up pair of headphones) functional.

She also described how much analyzing and grading and adapting were important in her ability to provide occupation-based interventions in a client-centered manner.

Another therapist discussed the need to prioritize what he could do with clients based on scheduling, the number of sessions allowed, and using a client-centered approach to reach client outcomes. He stated, "I think sometimes that may affect it and so you really have to pick and choose, okay what can I work on that will help them the most?" In addition, a third therapist discussed how she would use a single intervention or activity to address multiple areas so that she could be client-centered, while still addressing performance area deficits during therapy sessions.

> If I need a patient to work on endurance or balance, and they like to crochet, then it's like, alright well, let's stand and do this, so then they're thinking, they're working on their crocheting and here I am, yes, I want them to do that too, but I'm looking a whole lot of other stuff at the same time.

The therapists discussed that they required using clinical reasoning skills throughout the entire occupational therapy process, beginning with evaluation throughout discharge. To clinically reason, the therapists also expressed the skills needed to be a good therapist, including

creativity, innovation, client-centered, and decision-making regarding the client's plan of care for optimal outcomes.

Therapeutic use of self. The participants articulated that they had to create positive relationships with their clients to work together as a team and to help clients meet their outcomes. One therapist also highlighted that she had to use the therapeutic use of self when clients refused a therapy session to encourage them to take part in therapy, while another described the give and take relationship, with trust-building, to keep the relationship moving toward the end goal. He stated that it is:

> kind of like a working relationship you have with them, so, um, being able to get the sale done, helps to get them to work with you on, you know, again in the future, and also accomplish what they need to accomplish.

By using therapeutic use of self, the therapists felt that they increased client motivation, improved participation in therapy sessions, and worked toward meeting client outcomes.

Assessment and evaluation. The participants also emphasized how they used the evaluation process to find out a client's previous levels of independence, living environments, and what was meaningful to the client prior to any treatment planning. One therapist noted, "on the evaluation, I'll ask them, you know how their earlier level of function was, what they did before." He also described using the evaluation process to "gather information to really see where they're living, how, how they were living before this injury occurred." Another therapist described the sequence of the assessment and evaluation process at her facility noting that she "evaluate[s] the patient first, um, and you know, we like, their transfers, their ADL status, um functional mobility." After the initial evaluation, she used what she referred to as the lifestyle

addendum to find out more about a client's preferences, hobbies, and typical daily routines. She said,

> we have a half an hour session where we do this lifestyle addendum and we literally are like, "take me through your day, um, like a normal day for you. What are your hobbies, what are your likes, what are your interests, like what are things that you absolutely hate that you would never, you know, fathom ever doing, um when you got home?" So, you know, we kind of rule those things out, um, and then it comes down to like little sections, of like, you know, what do you do, like, well, I work with a lot of the geriatric population, so, a lot of them tend to like the senior center.

It was clear throughout all interviews and the focus group that therapists used the evaluation and assessment process to gain further insight into their clients' prior level of functioning, interests, preferences, and meaning of activities and occupations to formulate a treatment plan.

Grading and adapting. The therapists also focused on the importance of having the ability to grade and adapt tasks, provide adaptive equipment, and be flexible during the therapy process so that they can provide the just right challenge for a client. One therapist, who has been practicing for 18 years, repeatedly noted that "you have to be able to grade activities" for every client and possibly throughout each session. Part of grading and adapting also included the use of equipment for changing the environment, one therapist noting the rationale was "so that they can function at an independent level." It was also crucial for therapists to highlight that each client is an individual, and thus there would never be treatment plans that looked exactly alike. It was important to the therapists that they modify tasks for each individual. One participant described this as

> everyone's situation is so different and it's not very cookie cutter, so you kind of have to be able to, uh, you know, tailor it, like if my patient only sponge baths and they never take a shower, then it's not functional to do that with them.

Goal setting, review, and achievement. Goal setting, adapting, and attainment was another main area that therapists focused on throughout interviews and the focus group. Safety of the client to be as independent as possible, client motivation, and the meaning for which goals held to clients were the most common areas of discussion. One therapist in the focus group noted that "we make sure that they are safe with that before they go home." While another focused on helping a client become as independent as possible at home. He noted that he helps them to "progress back to their prior level of function or adapting the environment so that they can function at an independent level."

All therapists mentioned an aspect of the need for client commitment because they reported that motivation and meaning to a client has a large role in meeting their goals in occupational therapy. One therapist provided the following description of goal achievement based on client meaning:

> It depends what you, they may, we may be really excited that they're able to wipe themselves. Or, that they're able to get themselves dressed, but they may still say, "I still have a hemiparetic arm." And say that "I didn't meet my goal." Um, so, I think it's the question of, you know, they, they're able to meet our goals but are they meeting their goals. So.

Another therapist provided an example of how it is essential to provide meaningful therapy (in her case, her grandfather); otherwise, it is unreasonable and will not help a client reach a therapist's outcomes.

> My grandfather, for example, never made a meal for himself in his entire life. So, to have him cook dinner, to have him, like, make a sandwich in therapy is stupid. He has never made a meal in his life. Even when he was at his peak when he was a Marine, he didn't make, he never cooked. Like, he went from his mom to his wife. He never made one meal in his entire life, so why are we expecting him to do that?

A third therapist described the importance of having meaningful goals for each individual client, stating that it is important "because then, if it is interesting, then they are going to put more effort into doing what you want them to do and getting towards the goal that you set for them."

One therapist noted that when a client meets his or her goals "it just makes therapy, I think more enjoyable and your, yah know, reaching those goals." She also stated that as occupational therapists, there is a distinctive role in finding meaning in therapy:

> Even if there's something special that the patient, again, is purposeful to them. We want to get them back to being able to do that, and that is one of our unique roles as OTs I think compared to some of the other professions in health care.

Another important aspect that the participants emphasized was that of goal achievement. The therapists described how clients met goals differently. One emphasized that every child she works with has exponential potential, so there is really no way that you can question if they will stop making progress. She described this by stating:

> Kids are funky. Like kids will surprise you. Kids who you think can't do anything. I don't think you can have a highest . . . I think you have to have what you have now and want a step ahead and then tomorrow have what you have now and want a step ahead . . . I think you have to take what you have today and then want a little bit more, and then

> when you get there, and when you get there want a little bit more. And when you get there, want a little bit more. But I don't think you can ever . . . put a cap on what a child can do.

Whereas, another therapist, who worked in home care, described goal achievement as something that is attained after the client no longer makes progress. She stated that after "I pretty much have exhausted everything, then I know that's their highest level." Which is when she can discharge them from therapy.

Use of occupation-based practice. The therapists also discussed the use of occupation-based practice and its importance in practice for clients to have meaning and purpose in therapy. After all initial coding of content, counting of the frequency of each of Wilock's (2006) areas of occupation, which provided a better idea of the focus of therapists when completing interventions with their clients, the top categories included attendance at schools and further education (five references), chosen and voluntary occupations and challenges (22 references), food preparation and hygiene (11 references), home maintenance and chores (five references), paid work (three references), providing food and shelter for self and family (three references), and recreation and leisure (12 references). The category of chosen and voluntary occupations and challenges included all the references to ADLS, which indicated the greatest focus for therapists being ADLs with their clients.

The therapists provided numerous examples of occupation-based practice interventions that they used with clients frequently. Those therapists who worked in home care primarily discussed basic ADLs and IADLs as occupation-based therapy. One therapist stated that he tries "to stay with the main meat and potatoes, so to speak, you know your daily bathing, dressing, grooming, cooking, cleaning, laundry . . . those are the main focuses." The therapists who

worked in home care also stated that showering was of high importance, but that they also would do interventions in the kitchen and, once in a while, drive with a client. The distinction was also made by a therapist about how simulating tasks is different from having the client do the actual occupation itself. She said

> So, occupation-based means, you know we're not, we're not simulating a dressing task, we're getting involved and we're dressing, you know, with the patients. And we're using the adaptive equipment, and we're taking showers, and, you know completing everything in its truest form.

The therapists who worked in a rehabilitation facility provided many rich examples of varying occupations, which they use daily with clients who are at the facility. They did state in the focus group that there are many ADLs completed by therapists with their clients so that clients can go home safely. However, they highlighted the many amenities they have at the facility to use with clients when needed.

> We have a fully functioning kitchen . . . we practice, um, meal prep, we practice retrieving items from cabinets, um, preparing beverages, baking . . . . We also have little kits, um, childcare kit, pet care, vacation planning . . . . We have the "easy street grocery store" so we can go grocery shopping with a cart. They can push the cart, so . . . . We also have a greenhouse, so if anyone loves to garden, in the spring and summer time, we can bring patients out there . . . past patients have liked to golf, so we golf, so like even practicing with them, you know. Using a putter, or we are going outside and doing that, it just makes therapy, I think more enjoyable and your, yah know, reaching those goals.

The other group of therapists, who worked in the school system, viewed occupation-based practice differently in that they described play as being the primary occupation being used

in intervention sessions. One therapist noted that, "I don't do like arm exercises in order to get them to be able to reach, I just have them reach and I have them play." She also noted that while some goals might be performance-based (i.e., cutting skills) during interventions, she does occupation-based interventions instead of focusing primarily on the performance skill. She provided the example of "if we're working on cutting, not just cutting paper, but doing a craft project . . . if we are working on hand strengthening, not just squeezing a ball, but playing with play-doh."

On a final note about occupation-based practice, one of the clinicians made a statement during her interview that was very poignant regarding the use of occupation-based practice as a profession. She said, "I mean, if you think about what we do, like our whole thing is *occupational* therapy, so of course, you need to use occupation, like, or you might as well be a physical therapist."

Professional Identity

The second theme that emerged from the data is the profession's identity. The participants noted that other disciplines and clients (including his or her family) do not understand what occupational therapy is or that therapists can work in a variety of settings. Another large concept arose with this theme of what therapists define as occupation, in general, and specific to their primary settings.

Confusion of occupational therapy. One therapist was very clear in her interview regarding her struggles to convince patients that occupational therapy is a profession and has value to their progression toward being safe and independent at home. She explained that clients "don't really know, they know what PT is, more than they know what OT [is]." She stated that if

she did not provide education on what the field of occupational therapy was, then she did not receive buy-in from patients, and then she had difficulty getting them to participate.

Another therapist described it perfectly, specific to how an occupational therapist persuades patients into participating in therapy. “It’s kinda like you’re a car salesman, you’re, you’re selling them on an idea, on OT, when you’re in the home.” The participants also acknowledged the importance of gaining a client’s trust to provide the best therapy possible. It was important that “while you are in their home, and you want to make them, just, have the confidence in you as a therapist.” The confusion was also noted in the school system, with teachers not fully understanding the role of the occupational therapist in the setting. One therapist described this by stating, “I get a lot of, ‘that’s what you are you are doing with them, what does that even mean for school, like, you’re just playing games with them.” This confusion makes it difficult for therapists to provide effective interventions to clients in multiple settings.

Defining occupation. During each interview and the one focus group, the therapists defined occupation. The participants provided multiple definitions and had a consensus that occupations are activities that one does throughout his or her day that are meaningful and purposeful. The participants also noted that what is meaningful and purposeful varies from one person to another and can vary based on the role a person is fulfilling. One therapist provided the following definition:

> If you’re retired, I see your occupation as being, you know whatever it is that you accomplish on a day-to-day basis. From getting up in the morning, to getting ready to go to bed, and everything in between. Whether you cook your own meals, do your own laundry, do your own dressing, bathing, um. That’s what I look at as far as occupation in that kind of age group. You know, if you are a kid, your occupation is probably playing

with a toy or learning new things in your environment. If you are a soldier, your occupations are whatever you do in that. So, it's whatever you, um, do from a day-to-day basis.

While another therapist described occupations as being "everything that you do in a given day, so whether it be getting dressed, going to work, um . . . in peds it would be playing." A third therapist described occupation as looking "like doing things . . . that you would . . . that if you did not have a disability, you would be doing or doing things that are meaningful and purposeful." Finally, another participant stated it is "anything you do during your day, and you have, uh, value for it . . . it varies by person and what they hold valuable to their existence."

Facilitators and Barriers to Use of Occupation-Based Practice

Throughout the interviews and focus group, the participants identified and described those influences in their use of occupation-based practice. Some of those were specific facilitators and barriers, while others described the use of occupation-based practice is not automatic, and often one has to navigate the systems of the workplace. Such systems included billing, goal writing, and productivity. The discussion of the use of the medical model, often used in practice, was also identified, and how some therapists work on "preparing" clients to complete occupation-based practice, rather than the use of occupation itself. Other therapists discussed conflicting viewpoints of the clients they work with, those who may not want to participate, or who are not motivated to complete therapy.

Facilitators in use of occupation-based practice. During interviews with the participants, all but one therapist came up with multiple facilitators to the use of occupation-based practice. Many of the facilitators revolved around environmental factors, such as access to equipment, space in the facility or home, and the client being in his or her own home. The

participants noted that having access to adaptive equipment, such as tub benches, shower seats, reachers, dressing sticks, and other pieces of equipment made it easier to provide occupation-based practice. Other variables included time flexibility with patients, caregiver support, coworkers, and client motivation. The group of therapists in the focus group all worked at the same rehabilitation facility and explained that they do not need to worry about time restraints for any client, regardless of their payer source. They all expressed how lucky and how unusual it is to not have to worry about productivity or treatment-required minutes. They explained:

> We can treat our patients for what's appropriate for them. So you can do a half an hour, I mean, you know, sometimes they need more, obviously, and sometimes you do not have enough time in your day, but, at least a half an hour a day and up to an hour or an hour and a half.

Another participant discussed how useful it was to have caregivers (often family members) who could be present at therapy sessions as well as assist with carryover when the therapist was no longer there. In addition, she discussed the helpfulness of colleagues who all attended "a case conference every week, we bounce ideas off of each other and anytime I come across something new that somebody suggests . . . I try to incorporate that . . . I am always . . . bouncing ideas off of my coworkers." She found that collaboration with colleagues was useful in her treatment planning of occupation-based interventions. It was also noted that when a client is in his or her own space or home, it is easier to provide occupation-based practice sessions, and with the use of occupations, the participants found that clients had better and more motivation to complete and achieve therapy goals. Finally, one participant highlighted that she does not believe there need to be any facilitators for using occupation-based practice, because she "think[s] it's really the only way to go."

Barriers in use of occupation-based practice. While there were multiple facilitators identified, there were also barriers noted when the therapists were trying to use occupation-based practice. The most common barriers identified by the participants included client motivation, client diagnosis (medically complex patients), certain roles that are difficult to include in therapy (such as caretaker of a small infant), therapy sessions that occur outside the patient's home, resources (such as equipment or limited space), and being a male therapist. There were also multiple systems issues that included the time required with a patient, productivity, insurance restrictions, and preset goals in computer systems.

Often, the therapists noted when a client lacks motivation, and the therapists have difficultly using occupation-based practice, especially when they "only want to walk" and do not understand why occupational therapy is there to help them get dressed. This challenge increases when clients have a diagnosis or injury where they may have added restrictions, such as orthopedic precautions, deficits in cognition, are medically complex, are reliant on a ventilator, or lack awareness or arousal. One therapist described the barrier as, "sometimes if they have an orthopedic injury that may prohibit them from physically doing some of the meaningful occupations that they once, you know, did, so, some of the times, it is probably their diagnosis." This same therapist discussed the trouble in providing occupation-based interventions with clients that have a higher level or more difficult roles to fulfill, such as being a mother or caretaker to a small infant.

> One that I usually find, like, trouble with is when someone, when their role is a caretaker, um, like say they are a caretaker for an older mother or even their younger child. We can simulate it, but it's really hard to, um, like, we have a doll to place a diaper on, but it's not the same as a squirming baby.

The participants who did not work in home care also expressed the barrier of not being in a client's own home or space. While they could simulate the home the best they could, they explained that simulating occupations was not as good as actually doing the occupation in the patient's own environment. Another environmental barrier was that of limited space. The therapists who worked in home care emphasized they often worked with patients in small homes or apartments. The barriers of not being able to fit adaptive equipment or the patient and therapist in a small space, such as a bathroom, were also noted. Finally, the male therapist discussed how doing some of the basic ADLs with female clients was often challenging, as many refused to shower or get dressed in front of him. He explained, "I think sometimes for a male therapist, for me, . . . I'm not saying, being in a home with an elderly lady, um, it may make it more of a challenge to see those type of goals."

In addition to the barriers discussed above, there were multiple identified barriers as being issues of a system, such as insurance restrictions, computer software for documentation, and company policies on productivity requirements. Insurance was discussed at all interviews and many therapists identified concerns or barriers regarding how often and long they could see patients based on the payer source. One therapist said it "put[s] a limit on what you can do, what you can't do, and then they review things." They also noted that because of these restrictions they often had to prioritize what they could work on with a patient, saying "I think sometimes that may affect it and so you really have to pick, okay what can I work on that will help them the most?" Thus, limiting the ability to use occupation-based practice with clients.

The companies for which the participant's works also have system barriers with set productivity requirements, which limit the flexibility and timeframe that a therapist can spend with a client. Companies also use a variety of computer systems, and one therapist explained that

it is challenging to write occupation-based goals in the program her company uses and stated that it "kind of sucks, because we have like, pre-chosen, pre-written goals with our tablets. You cannot customize any. I have come across situations, where literally, no goals are appropriate." She also stated that she will spend additional time writing additional goals that are not measured for insurance purposes.

> We have to have the functional goals, just for insurance purposes . . . then, I do a whole slew of goals that are tailored that are meaningful to the patient, and while they're not necessarily like scored for insurance, I add them to the treatment plan because it is a reminder for me of the things that are meaningful to them.

This allows her to create occupation-based goals that are meaningful, but this is a barrier in that she has to add them to a treatment plan that will not allow for her to measure them and report back to insurance on patient progress.

Medical model. During interviews, the participants also presented that "it seems like a lot of people are taking biomechanical approaches or using more robotics or that type of thing . . ." rather than using occupation-based practice. When patients are "weak, you do your strengthening," or if you need to work "on their bilateral . . . coordination, or their fine motor skills, pincer grasp," then it is addressed first in therapy prior to the use of occupation-based practice. One of the therapists also stated the importance she feels balance has with the population with which she works.

> If you don't have your balance, then you can't perform functional mobility, and you can't, you know, and if you don't have a wide base of support then you can't work on your balance, and so we really focus, it's almost like we're almost OT/PT.

This view of using the medical model also presents as a barrier to the use of occupation-based practice, especially when therapists highlight the need to do these interventions before introducing any occupation-based interventions.

With the analysis of the three themes presented, the researcher developed a new theory from the data to describe how therapists conceptualize occupation-based practice and what it looks like, the constructs (and their relationship) of occupation-based practice, and the facilitators and barriers currently occurring when using occupation-based practice. The presentation of the new theory is that of the Dynamic Process of Occupation-Based Practice model.

Answers to Research Questions

The completion of this study provided the answers to the three main research questions. Therapists answered the first question of how do therapists conceptualize occupation-based practice with participants describing how they viewed and conceptualized occupation-based practice. Occupation-based practice is meaningful and purposeful to the client. The therapists explained that doing the actual occupation was occupation-based practice, while simulation of an occupation was not. They also discussed many examples of occupation-based practice in the various settings in which they worked, ranging from bathing, completing assignments for school, shopping for groceries, cooking, and many others. The participants in this clearly provided descriptions and examples as to what occupation-based practice is and looks like in practice in a variety of settings.

The second research question was, what are the constructs of occupation-based practice, and how do they relate to each other? Throughout the interviews and the focus group, the participants described the multiple components of occupation-based practice in all therapeutic

interactions. After completing data analysis, these components were combined into four main constructs. The constructs of occupation-based practice are the authentic occupation, engaged participation, meaningful and purposeful value, and therapeutic intent. Authentic occupation is that of the use of actual occupations and not simulated occupations. Meaningful and purposeful value refers to the necessity of the occupations having meaning and purpose for the client. Therapeutic intent is the deliberate use of occupation to address a client need in each therapeutic interaction. Without authentic occupation, meaningful and purposeful value, and therapeutic intent, there would be little to no engaged participation. Engaged participation is that of active involvement in the therapeutic interaction. Thus, these constructs relate to one another and cannot be used in isolation from one another. Figure 6 displays the connections between these four main constructs.

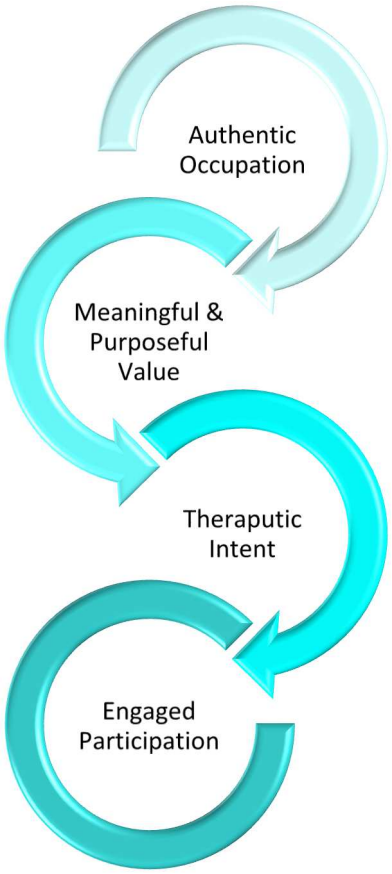

Figure 6. Constructs of occupation-based practice.

The third research question was, what are the facilitators and barriers to using occupation-based practice? Therapists could easily identify both facilitators and barriers in their ability to use occupation-based practice in therapeutic interactions. The therapists identified multiple components, some as facilitators in some circumstances and barriers in others. These factors included client motivation, client health status, the physical environment (including location, space, equipment, and resources), time, relevant others, therapist-client fit, therapist experience, and therapist clinical reasoning skills. There were also factors that were identified only as facilitators and included intraprofessional collaboration and flexibility. Finally, there

were components that were only identified as barriers and were complex client roles, and insurance and documentation restraints.

Theory: Dynamic Process of Occupation-Based Practice

A theory depicting the process of influences on occupation-based practice evolved and represents the Dynamic Process of Occupation-Based Practice model and is pictured below (see Figure 7):

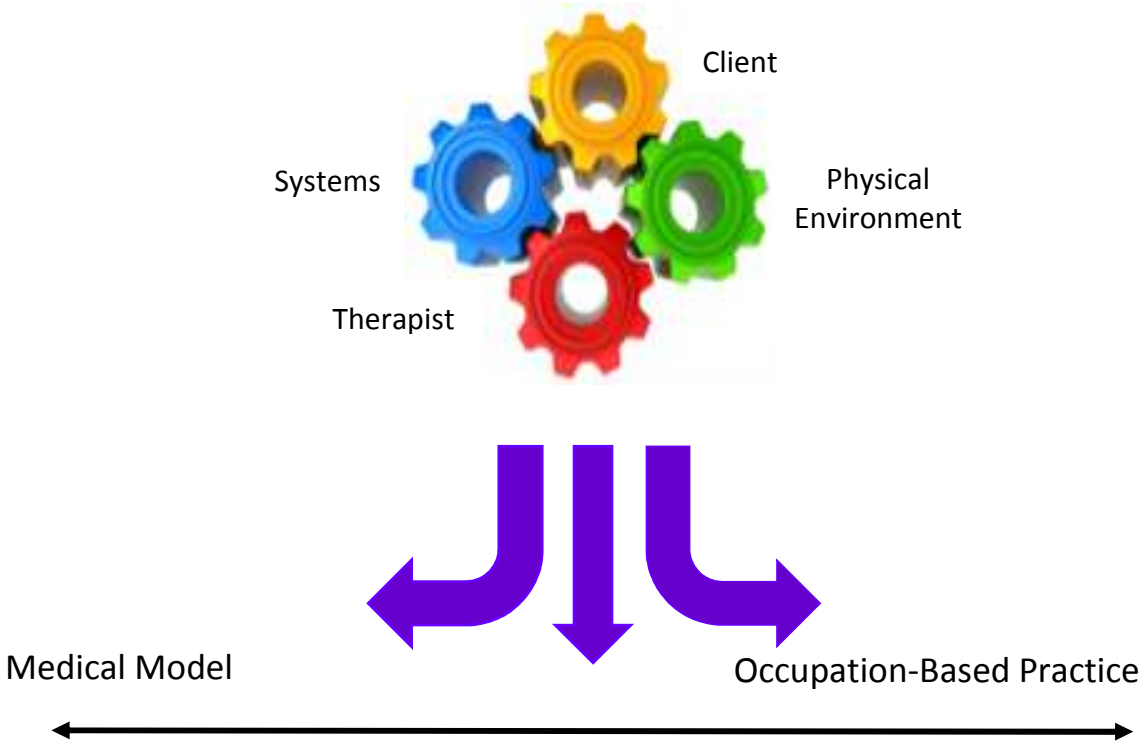

Figure 7. Dynamic process of occupation-based practice.

This theory depicts the process, considerations, and influences all therapists encounter in the determination of therapeutic interactions used with clients, resulting in approaches that fall along a spectrum between medical model based or occupation-based. The decisions that therapists make regarding the occupational therapy process are influenced by components that determine their use of occupation-based practice. There are multiple components and each of

these can be facilitators, barriers, or both, depending on the therapist, circumstances, or environment. An assumption of this theory includes acknowledgment that occupational therapists possess a baseline approach to client care that is more philosophically aligned toward medical model approaches or occupation-based approaches based on a therapist's knowledge or belief about occupation and his or her understanding of occupation-based practice. This underlying baseline philosophy contributes to where a therapist begins in his or her decision-making process about therapeutic approaches to use with clients. Each therapist begins each therapeutic interaction with the preset foundational understanding, knowledge, and belief about occupation and its health-promoting qualities; however, the therapist has the potential to change that perspective over time with additional knowledge and experience.

Theory Constructs

The constructs can be categorized into four main influencers and includes systems, therapist, physical environment, and client. The representation of these constructs are the four interlocking gears at the top of the image, as these factors can influence one another and/or change throughout the occupational therapy process. Each of the constructs and its components encompass facilitators, barriers, or a combination of the two depending on the context and therapist. Below these constructs (the four interlocking gears) are arrows that represent the direction of the therapeutic interactions in occupational therapy practice. These arrows represent the output of the four constructs that have influenced a therapist in his or her decision-making process. This decision then results in the therapeutic interaction, which then lies along the continuum at the bottom of the graphic. A double-arrowed line at the bottom of the image represents this continuum. The extremes of this spectrum are medical model on one side (left) and occupation-based practice at the other side (right). All therapeutic choices fall somewhere

along this continuum between medical model and occupation-based practice. The location along that continuum is a result of the facilitating or restricting influences of the therapist, client, physical environment, and system. Another contributing factor that determines where a therapeutic interaction falls along the continuum is by assessment of the four constructs of occupation-based practice: authentic occupation, meaning and purposeful value, therapeutic intent, and active engagement.

As described above, there are four main influences that include: systems, physical environment, client, and therapist. Each of the components can be a facilitator, barrier, or variable, depending on the circumstances. These constructs include multiple components and will be described further. The system's construct includes the components of insurance restraints, documentation systems and requirements, and time. Insurance restraints would include payment reimbursement and restraints on the amount of therapy provided, based on a payer source. This variable of insurance restrictions is a barrier, as it makes it more difficult to provide occupational therapy services in an occupation-based manner. The next component under the systems construct is that of documentation and the systems and requirements therapists must use and follow. These are barriers, as many of the systems have preset choices that are not occupation-based and therapists are unable to change them. The last component under the systems construct is that of time. Therapists view this as both a facilitator and a barrier, depending on the workplace and situation. Time can be a facilitator if there is flexibility in a therapist's schedule but can also be a barrier with the high productivity requirements and large caseloads. The system's construct is often determined by the organizational and institutional context of the workplace, and these are often not choices that a therapist is able to make but are predetermined for them.

The next construct is that of the physical environment. The two components are that of the environment and supplies and resources, both of which can be both a facilitator and a barrier, depending on the therapist and situation. The environment consists of both space and location and can be a facilitator if there is a lot of space. The space is set up in an ideal configuration, or the safety of the space. Space can be a barrier if there is not a lot of space, if it is crowded, or if it is not safe or has safety hazards. Location can also facilitate the use of occupation-based practice, especially when in the client's own home. However, location can also be a barrier when in a setting where it is unfamiliar or hospital-based. The other component of the physical environment is that of resources and supplies. When a therapist has enough equipment and supplies to facilitate occupation-based practice, it assists in providing occupations throughout therapeutic interactions. Examples of these are occupation-based kits (i.e., childcare, restaurant management), mock grocery store, an adapted car, and so forth. However, when therapists do not have access to resources and supplies it can be challenging to use occupation-based practice, and thus it becomes a barrier.

The next construct is that of the client; this construct includes three components: client health status, the complexity of client role responsibilities, and client motivation. The client health status can be a barrier or facilitator. If the client is medically complex (such as a client who requires a ventilator or oxygen, or who is not able to move physically) it is challenging to use occupation-based practice, as the client is unable to participate in therapy fully. However, the client health status can also be a facilitator if the client is able to participate fully and is not (or no longer) medically complex. The component of complexity of the client role responsibilities is a barrier to the use of occupation-based practice. When a client has complex roles that he or she needs to return to (such as caring for a child or returning to work as a construction worker) it can

be difficult for therapists to use occupation in a safe and appropriate way in each therapeutic interaction. Finally, client motivation can be viewed as a facilitator and barrier, depending on the client. A client who has high motivation to improve allows the therapist to provide occupation-based practice, whereas a client with low motivation may not be willing to participate in occupational therapy at all.

The fourth construct is that of the therapist and include multiple components. These components are relevant others, therapist-client fit, therapist experience, clinical reasoning skills, and intraprofessional collaboration. Relevant others include a client's family members or caregivers that can assist in therapeutic interactions and/or carryover. When clients have relevant others, they are considered a facilitator to the use of occupation-based practice. The therapist-client fit is another component of this construct and can be considered a facilitator and barrier. When the therapist and client have a good fit, it enhances the use of occupation-based practice; however, when they do not have a good fit, it can be a barrier. This involves more than rapport and can include differences in gender or religion (i.e., a female client refusing to allow a male therapist to help her take a shower). The next component is that of therapist experience. This, too, can be a facilitator or barrier, depending on the therapist and situation. If the therapist has had an education supporting occupation-based practice and/or has work experience where they were able to use occupation-based practice, it is a facilitator. However, if a therapist is lacking in his or her educational experience and/or work experience with occupation-based practice, it can be a barrier. Clinical reasoning is another component of this construct and is the process a therapist uses when planning and executing therapeutic interactions. Therapists can use clinical reasoning skills to use occupation-based practice or medical model therapeutic interactions, thus it can be considered a facilitator or barrier. The final component of this construct is that of

intraprofessional collaboration. This occurs when therapists collaborate with one another to problem-solve (especially more complex or complicated clients) to facilitate the use of occupation-based practice.

This model of A Therapist's Dynamic Use of Occupation-Based Practice describes the process that occurs for each therapeutic interaction a therapist has with a client. The four constructs of systems, physical environment, client, and therapist influence a therapist in his or her decision making to be able to use occupation-based practice. The output of this decision results in actual practice, which can land anywhere on the continuum from the medical model based therapeutic interactions to occupation-based. Each and every therapeutic interaction (with the same therapist and client) can move up and down this continuum. For example, a therapist who has had a strong education in occupation-based practice with the understanding of its importance and who believes in the use of occupation as a therapeutic medium could be working in an acute care setting. In this setting, there could be a preset documentation system with medically-based goals or a lack of equipment and resources; thus, the therapist would have to use more medically-based assessments and interventions. Another example of how this model works would be a therapist who did not have a strong education in occupation-based practice, who does not believe in the therapeutic value of occupation, and who lacks the understanding of its use, but who works in a long-term rehabilitation where there is a mock bank, grocery store, car, and kitchen. This therapist has schedule flexibility and an occupation-based documentation system and uses primarily occupation-based practice in each therapeutic interaction.

Summary

This study sought to answer the research questions: (a) How do therapists conceptualize occupation-based practice, and what does it look like? (b) What are the constructs of occupation-

based practice, and how do they relate? and (c) What are the facilitators and barriers to using occupation-based practice? A grounded theory approach was used and after data was collected and analyzed, three main themes emerged from the data. The three themes are (a) facilitating doing, being, and becoming; (b) the profession's identity; and (c) facilitators and barriers to use of occupation-based practice. From these themes, the theory of dynamic process of occupation-based practice was created. This theory describes the process that a therapist uses for each therapeutic interaction. The constructs that influence this process include the therapist, client, physical environment, and systems. These influencers impact a therapist's decisions and the output results in practice, which then can land on the continuum that has the medical model and occupation-based practice on opposite ends. This represents the dynamic process therapists go through when providing therapy to their clients. A discussion of this relationship between the constructs and the theory is included and provides further clarification and understanding of the this study's findings.

Chapter 5: Discussion

The purpose of this qualitative grounded theory study was to gain a better understanding of occupation-based practice and the constructs that make up occupation-based practice, including how they are interconnected and what the facilitators and barriers are incorporated in the use of occupation-based practice. This chapter discusses the answers found to the research questions, the interpretation of the findings, and the relationship between the findings and current literature. In addition, this chapter explores the relationship between the findings and the guiding theoretical perspectives of diffusion of innovation (Rogers, 2003) and OPH (Wilcock, 2006). This chapter also reviews implications for practice and education and concludes with the limitations of the study and recommendations for future research.

This chapter includes a discussion about potential future research into the research questions: (a) how do therapists conceptualize occupation-based practice, and what does it look like? (b) What are the constructs of occupation-based practice, and how do they relate? and (c) What are the facilitators and barriers to using occupation-based practice?

The theory of dynamic process of occupation-based practice illustrates the method a therapist uses to determine the type of therapeutic interaction he or she uses with a client. The constructs of therapist, client, systems, and physical environment influence the process, which includes multiple components and influence a therapist's decision-making process. Once a therapist decides about a therapeutic interaction, it falls along the continuum anywhere between the extremes of medical model-based interactions and occupation-based practice. This process is dynamic and ever-changing and represents the variability of each therapeutic interaction, even in a single therapy session with a single client.

Interpretation of Findings

This study provides and defines the four constructs that comprise occupation-based practice and a theory or framework of the dynamic process, which occurs for every therapeutic interaction. It also discusses how facilitators and barriers influence the process of using occupation-based practice during therapeutic interactions and where these interactions lie on the practice continuum between medical model and occupation-based. This is one of the first frameworks presented in the profession of occupational therapy that describes the process and all the constructs and components of occupation-based practice.

Interpretation of Themes

The three themes that emerged from this study were (a) facilitating, doing, being, and becoming, (b) the profession's identity, and (c) facilitators and barriers to use of occupation-based practice. The first theme of facilitating doing, being, and becoming provided the endorsement in that the therapists' value occupation-based practice throughout the occupational therapy process. The participants noted that when they used occupation in practice, their clients had better outcomes, met the outcomes faster, and had increased client satisfaction. While there were no frequencies of use gathered during this study, the therapists who noted using occupation-based practice also expressed increased fulfillment and satisfaction as a therapists. Based on the stated positive outcomes for the client and the therapist, the use of occupation-based practice throughout practice is recommended.

The second theme, of the profession's identity, justified the need for completion of this study. Occupational therapists provide a unique service that is often difficult to define. This was clearly articulated by the study's participants with the confusion of the profession with clients, other professionals, and reimbursement bodies. This has been a challenge for the profession

since its inception and makes it difficult to provide services and prove to reimbursement bodies the profession's need and worth. The differences in professional terminology is part of this issue, which causes more confusion and ambiguity. This is clear with the terms occupation-based, occupation-centered, and occupation-focused and how they are erroneously used interchangeably in the profession (Fisher, 2013). Without some clarification and consistency, the profession will continue to experience confusion of its identity.

The third theme of this study, facilitators and barriers to use of occupation-based practice, identified how multiple components can influence the use of occupation-based practice in a positive way, negative way, or both. For example, in-home care services are provided in the person's home. One therapist described being in a person's home as a barrier if the person has a small apartment where it is difficult to complete any occupations because of the space. Whereas another therapist stated that being in a person's own home acts as a facilitator because they can use all the person's own supplies to be truly occupation-based. While physical environment was one of the components, it was not the main component identified by the participants. The physical environment was only one of the components with a large emphasis on the social environment, cultural context, and temporal context. The role of the caregiver and other colleagues supporting the client and the therapist allowed for easier integration of occupation into practice. The importance of the cultural context with having support of the facility and/or administration was another component that contributed to the successful use of occupation. Finally, the temporal context was important, with multiple participants (working in various settings) who expressed that productivity expectations, the requirements of reimbursement bodies, and the current delivery model of services affected their ability to use occupation. The consensus was that a set number of treatment minutes and being required to prove to insurance

the value of occupational therapy in a medical model delivery system made it difficult to use occupation. Whereas, those who worked where there were no set treatment times or frequencies used occupation easier in practice. Regardless of the multiple aspects of context that emerged from this theme, it is important to note that the context is out of the therapist's control. If the contexts and environments are overall barriers to using occupation-based practice, the training and belief of a therapist will only allow for the use of occupation-based practice with supportive contexts and environments.

Interpretation of Constructs

This study provides the four constructs of occupation-based practice, which create a more tangible concept. The four constructs of authentic occupation, meaningful and purposeful value, therapeutic intent, and engaged participation delineate the concrete components required to use occupation-based practice. All of these constructs, existing in unison lie somewhere on the continuum between the medical model and occupation-based practice. Each construct can vary with how extensively aligned it is with occupation-based practice. The depiction of the extent of alignment toward occupation-based practice is as a meter that is filled or empty, or somewhere in between. In Figure 8, the meter illustrates various degrees of fullness. The fuller the meter, the more occupation-based; the emptier the meter, the further toward the medical model.

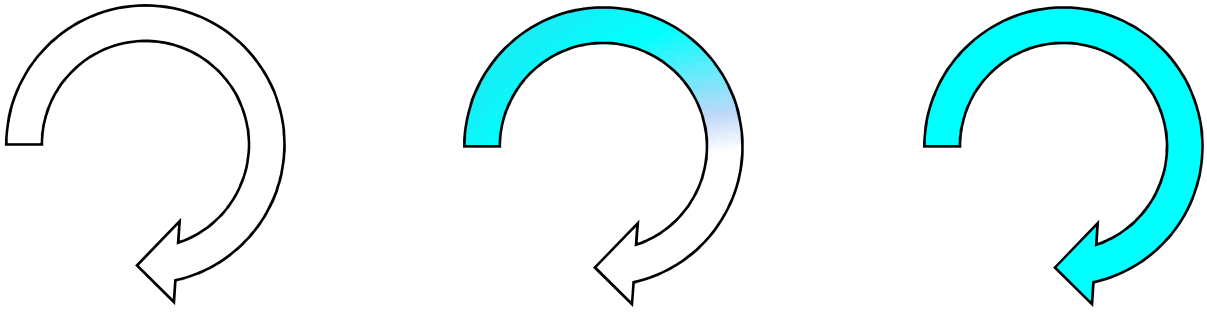

Figure 8. Construct meter.

The representation of the first construct of authentic occupation is of being empty when there is no use of occupations, such as a therapist having a client do rote exercises. If this meter is half full, a client could be doing one step of an occupation, such as squatting to work toward being able to complete laundry management. If the authentic occupation meter is three-quarters full, a client could be stepping in and out of a bathtub at a facility to simulate the occupation of taking a shower. When true authentic occupation is used, a client would be driving his or her car, this would represent a full meter.

The second construct of therapeutic intent on the above meter would be represented based on how intentional therapeutic interactions occur. If the meter is empty, a therapist would be filling treatment time for the sake of being required to provide a set number of minutes of intervention. If the meter is half full, the therapist is using therapeutic interactions that are beneficial to the client, however, they are not focused on the client's goals. If this meter is full, the therapeutic interaction is deliberate in that the therapist is addressing specific goal areas.

The third construct, meaningful and purposeful value, also uses this meter. An empty meter is reflected when a therapist is the full decision maker during therapeutic interactions. A half-filled meter is representative of the client being provided a few choices from which he or she chooses during the therapeutic process. If the meter is three-quarters full, the client will adopt the value of the therapist, and a full meter is when the therapeutic interaction is client-driven.

The final construct of occupation-based practice of engaged participation is also represented by this meter. When the meter is empty, the client is the passive recipient of therapy, such as receiving passive range of motion. When the meter is half full, there is no client

motivation included and therapists use a mechanical manner to approach the therapeutic interaction. Finally, if the meter is full, the client is fully invested and motivated to complete the occupation.

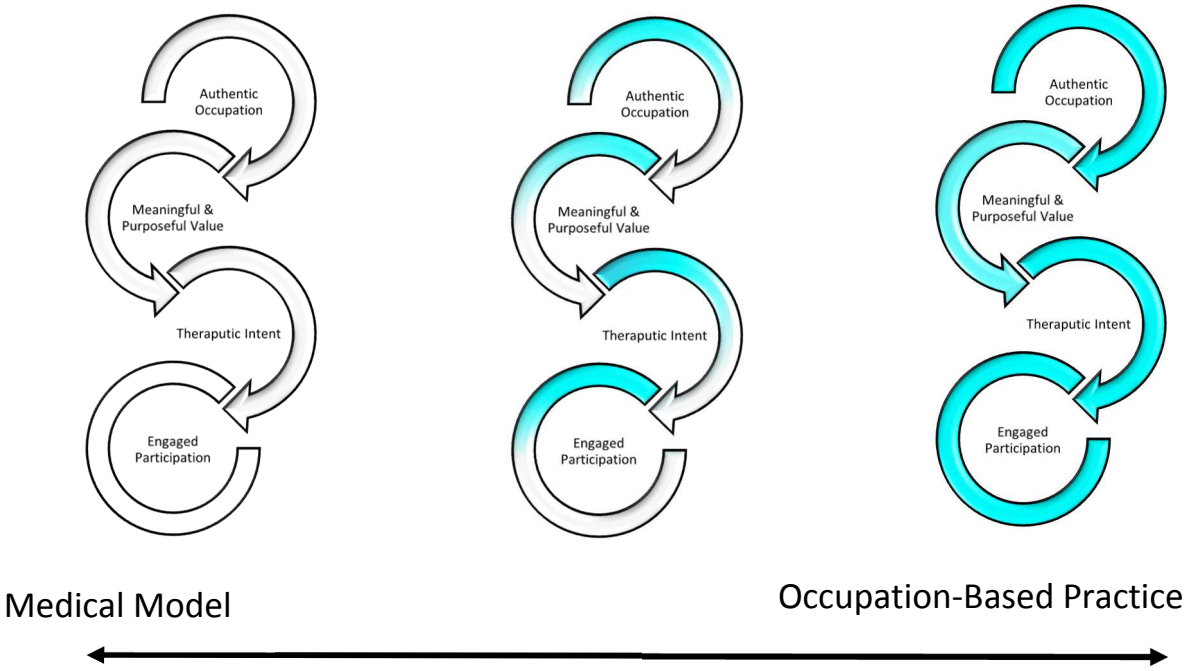

Figure 9. Construct determinants on use of occupation.

Interpretation of Developed Theory

The theory of dynamic process of occupation-based practice provides a theory or framework for the process of occupation-based practice in the profession of occupational therapy. This process occurs regardless of setting, population, or time, and it occurs with each therapeutic interaction a therapist has with each client. The four components of systems, therapist, client, and physical environment impact all therapeutic interactions, with each component having a multitude of facilitators and barriers impacting his or her decision. All of the constructs of occupation-based practice assist in determining where on the continuum a therapeutic interaction occurs. Figure 9 provides a visual for this below.

The relationship of how full or empty a meter is directly relates to the understanding of each construct of occupation-based practice. When the individual judgment of each construct occurs, however, all four are summative. The more filled each meter is, the more occupation-based the therapeutic interaction. Conversely, the less full the meters are, the greater emphasis is placed on client treatment via the medical model for each therapeutic interaction. However, each construct exists independently of each other and one or more constructs could be full and the others empty or very low. There are infinite possibilities and combinations with the amount each meter could be full for each of the constructs, but the more the meters are full, the more occupation-based the therapeutic interaction.

By having constructs clearly defined and the decision-making process of using occupation-based practice, therapists, administrators, and reimbursement bodies can further define, understand, apply, and evaluate practice in a more objective way. By providing this structure, the profession can improve the ability to articulate its role and identity clearly. The profession has had difficulty with professional identity since its inception (Gillen, 2013). This study provides a clearer way to define occupation-based practice, which is the foundational belief of the profession.

Relationship of Findings to the Literature

Current literature supports the use of occupation-based practice throughout the health care continuum and the life span. There is evidence, although limited in direct causation, that using occupation-based practice improves health and well-being (Hocking, 2009; Wilcock, 2007). While the Well Elderly Study did show the direct relationship between the use of occupations and well-being, the study was completed with healthy individuals with a preventative health care approach (Jackson et al., 1998). This study did not view those clients

who are ill or disabled and did not consider the therapists who work with this population. While there is limited research on the connection between use of occupation and health and well-being, many therapists are not using occupation in practice (Kennedy et al., 2002; Munin et al., 2010). The AOTA also has identified the use of occupation-based practice as one of its main initiatives in the centennial vision (AOTA, n.d.b.). Throughout the literature, there is a main theme of therapists lacking the knowledge or ability to use occupation-based practice because of a multitude of barriers, including reimbursement, assessment requirements, and personal belief systems (Ericksen, 2010; Estes & Pierce, 2012; Humphrey & Wakeford, 2006; Kennedy et al., 2002). The findings of this study depict the practitioner belief that using occupation in practice is important and valuable throughout the field, which agrees with the current literature. The participants also noted that multiple components of the decision-making process for therapeutic interactions, although this was not explicitly stated in the currently available literature. However, there were also some inconsistencies with many therapists focusing on biomechanical or medical model therapeutic interactions versus those in the study who reported being much more focused on occupation, which was found in literature from pediatrics through elderly populations.

As previously noted, the AOTA has a primary initiative of therapists using occupation-based practice throughout the life span and health care continuum (AOTA, n.d.b.). The findings in this study revealed that the therapist's views were inconsistently aligned with the AOTA's occupation-based initiative. However, the participants all highly valued the idea of using occupation-based practice, although it was not clear if their practice was also aligned with all therapeutic interactions. While this study did not explore the frequency or extent of occupation-based practice, the findings did support the initiative in highlighting the importance of its use throughout therapeutic interactions. The participants of this study also acknowledged the barriers

therapists face when attempting to use occupation-based practice, while others reported the use of medical model interventions in various settings, which does not support the AOTA's initiative.

The literature also highlighted how therapist beliefs and perceptions are important in whether a therapist will use occupation-based practice. These beliefs and perceptions are often based on education and experience (Ericksen, 2010; Estes & Pierce, 2012; Humphrey & Wakeford, 2006). The results of this study were that therapists highly valued the use of occupation-based practice. The participants had a mixture of bachelor's and master's level degrees from a multitude of colleges and universities. While the backgrounds of the participants were different for each therapist, their value for occupation-based practice was constant. While these are contributing factors, they were not found as the primary reasons, as all therapists in the study used occupation-based practice regularly. It is also noted in the literature that many therapists have difficulty defining occupation and how to use occupation in practice (Munin et al., 2010). The lack of a consistent definition contributes as to why therapists do not use occupation-based practice. In this study, only one participant had difficulty defining occupation, and thus also had difficulty articulating how she used occupation in her practice. However, the other eight participants did not have any trouble and had clear and accurate definitions and, in turn, could describe the many uses in which occupation occurs in daily practice.

Another area in the literature was barriers as to why therapists were unable or had difficulty using occupation-based practice. Some of those reasons included a lack of theoretical knowledge and not using occupation-based assessment tools (Ericksen, 2010). In the literature, billing constraints and the required outcome measures were also noted in the literature as being barriers to using occupation-based practice (Kennedy et al., 2002). The participants in this study

also identified a lack of assessment tools that were occupation-based, billing constraints, and the required outcome measures that do not capture occupational performance and thus do not support the use of occupation-based practice. Those in this study also identified more barriers than the literature, including documentation systems, components of the physical environment, and client factors. However, the participants agreed that these were barriers, but that they could still use occupation-based practice during therapeutic interactions.

Relationship of Findings to Guiding Theoretical Perspectives

This study used the OPH model (Wilcock, 2006; Wilcock & Hocking, 2015) and the diffusion of innovation (Rogers, 2003) to help guide and analyze the study and its data. A discussion of each of these theoretical perspectives provided a different lens to analyze and interpret the data.

The Occupational Perspective of Health

The OPH model views the multifaceted relationships between people, occupation, environment, and well-being by using the concepts of doing, being, becoming, and belonging (Wilcock & Hocking, 2015). These concepts of the OPH guided the data analysis phase to help develop the theme of facilitating doing, being, and becoming. Doing is the active occupational engagement that is important and purposeful to a person. In this study, the therapists described the facilitation of using occupations in practice to provide important and purposeful therapeutic interactions to help their clients improve their occupational outcomes. This researcher also applied this concept of doing to the actual therapeutic interactions that occur with the client. For instance, when deciding what medium to use in a therapeutic interaction, the therapists were influenced by the four main constructs (physical environment, therapist, client, and systems components). Once these influences had impacted the therapeutic interaction, the therapist's

choices landed somewhere along the continuum of medical model to occupation-based interactions. Thus, when the therapist used occupation-based practice, he or she facilitated doing of a meaningful and purposeful occupation.

The concept of being is how a person feels about what he or she is doing (Wilcock, 2006; Wilcock & Hocking, 2015). While therapists assisted their clients with the process of change and transformation so that they could complete occupations for the first time or in a new way, the main process of being in this study was that of the therapist. This study looked at the therapist's perceptions of him or herself and how he or she did or did not use occupation-based therapy. Most of the therapists clearly identify the occupation-based practice used on a daily basis and their belief that it was the most valuable type of therapeutic interaction to promote the best outcomes for their clients. There was only one therapist who had difficulty doing this, and this therapist did not have confusion as to how the process of occupation-based practice assisted clients in improving outcomes.

The third construct of the OPH model is that of becoming. Becoming describes the ongoing process of development, change, and growth, which occurs across a person's lifetime (Hitch et al., 2014; Wilcock & Hocking, 2015). While this study did not look at the lifetime of therapists, it is applicable in that each therapist had and will continue to develop and change his or her use of occupation-based practice throughout the remainder of his or her career. While each therapist had a foundation of the therapeutic interactions, he or she consistently does and has mastered experiences, and continuing education will shape how he or she approaches new or familiar clients. The value of occupation-based practice will also change over time, such as when working in a different setting or with a different population. These experiences and personal

goals will continue to impact this value and use as each therapist becomes his or her ideal occupational therapist.

The final construct of the OPH model is that of belonging. Belonging is the interpersonal component that connects others with the culture, community, and/or place (Hitch et al., 2014; Wilcock & Hocking, 2015). It is what makes a person's "life worth living" (Hammell, 2004, p. 302). While this study did not follow the therapists' journey, they begin to go through this process of belonging throughout their careers. Therapists also have a feeling of belonging prior to, during, and after the therapeutic interaction. This study did not examine this relationship, which is why it was not included in the theme of facilitating doing, being, and becoming.

The Diffusion of Innovation

The diffusion of innovation is a model used to describe the acceptance and implementation of new information, ideas, products, or beliefs that are different from what is currently being done or practiced (Rogers, 2003). Diffusion of innovation provided a framework for this study to help therapists identify where they identified in the process of change in using occupation-based practice. Those interviewed identified themselves as either being an early adopter or part of the early majority regarding using occupation-based practice. Prior to self-identification, each participant reviewed a visual of the model with a verbal explanation of the model and each category. The therapists who identified as early adopters explained they have used occupation-based practice from the day they became practicing therapists. Many of them also described that they do not know any other way to be an occupational therapist and it is necessary for all therapists to be using occupation as a primary means of assessment, intervention, and outcomes. The rest of the therapists identified as being part of the early adopters. These therapists made statements about needing to see how something works before

they are willing to try it. They also valued the use of occupation-based practice but wanted to make sure they saw positive outcomes with other therapists and clients before they had complete buy-in. This information was helpful in analyzing the data, as this researcher noted a connection between where on the diffusion of innovation continuum the participants were and how often the therapists self-identified as using occupation-based practice. One common trend was the setting in which the therapists worked, which played a large role in how quickly they adopted the use of occupation-based practice. One aspect not explored was whether the beliefs held by the therapists and their adoption of occupation-based practice occurred during their professional education.

Implications for Practice

The findings of this study have multiple implications for practice from the client's perspective to the therapist's perspective, all the way up to the administrative and reimbursement bodies' perspectives. Based on the findings of this study, the therapists all stated that when using occupation-based practice, they find better client motivation, improved outcomes, and higher participation compared to when they do not use occupation. This also influences client satisfaction, judged by the personal alignment of the therapeutic plan and interventions as well as speed and extent of recovery. While neither of these client outcomes was officially measured with statistical data, all of the therapists agreed that using occupation-based practice was the best option for all clients for goal attainment and satisfaction with therapy. Another benefit of using more occupation-based (or even occupation-centered) practice would provide for clients is that of distinguishing services between other professions. This would provide the differentiation of professions and increase the understanding of the profession's identity from the client through

administration and reimbursement sources. These implications for the client are vast and would improve outcomes, satisfaction, and understanding.

The therapists' viewpoints of the results of this study could be interpreted in a multitude of ways. Those therapists who do not or are unable to use occupation-based practice in their setting may have increased frustration at the inability to use the approach with clients. Because of increased frustration, therapists may continue to provide medical model interactions or be a catalyst in efforts to facilitate change. A therapist being a catalyst for change to use occupation-based practice could result in a change of practice in that setting or increased frustration if colleagues and the administration are not willing to support the change. By a therapist facilitating a change to occupation-based practice, he or she is improving client outcomes, client satisfaction, increasing understanding of the role of occupational therapy, and cultivating therapist fulfillment.

The results of this study also have implications for the context of practice throughout the health care continuum. The current delivery models in our health care system consist of a designation of frequency and duration determined by insurance companies. Third-party payers currently determine the frequency, intensity, and duration of care; however, the occupational needs of the client are not considered or aligned with occupation-based practice. The alignment of current reimbursement and delivery models are with the medical model, which grew out of biomedical guidelines associated with physical healing from illness and surgeries rather than formulating care based on the occupational needs of clients. As a result, there is a need to advocate for flexibility in delivery models that vary from specified session per week for standard lengths of time. Throughout the study, therapists clearly stated that the ability to use occupation often requires more flexibility. This required flexibility increases use of occupation regularly

with care since it is difficult to plan how long it will take to complete meal preparation or balancing a bank account with each individual client. While reimbursement can cause difficulties in occupation-based practice, the profession does have an opportunity to increase proof that occupational therapy is unique and has a value from other professions. Through occupation-based or even occupation-centered practice, the inherent value and uniqueness of occupational therapy will be proven to reimbursement sources, thus decreasing the confusion between other professions.

Another recommended change, based on the results of this study, is the physical space in which occupational therapist complete therapeutic interactions. Provision of occupation-based practice necessitates a context that allows for authentic occupation. This might mean that hospitals, rehabilitation facilities, skilled nursing facilities, schools, and so forth need to allow time outside of the facility to complete therapy and need to have spaces in which occupation can occur. Spaces in a facility might include a full kitchen, a washer and dryer, a car (or part of one), a bedroom with proper furniture, and so forth. By providing the necessary physical context, it will support the client and the therapist to complete occupation-based practice. These changes will not only support the client and therapist but will also provide the uniqueness of occupational therapy to the reimbursement bodies.

The results of this study also impact the administration of facilities and companies. By the administration providing support to allow for occupation-based practice, all therapy will have therapeutic intent; thus, there will not be any "wasting" of insurance money. To do this, the administration needs to provide the space for occupation-based materials and support therapists when they are trying to deliver services at a different temporal model than the medical model. The administration's understanding of the value of occupation-based practice is imperative so

that proper training is completed. This training will provide the administration with the knowledge necessary to support therapists in the use of occupation-based practice.

Implications for Education

The findings of this study have implications for the education of future and current therapists. The first implication is the opportunity at the entry-level point, when students are learning the how and why of being an ideal occupational therapist. Each school and program has the opportunity and ability to lay the ground-work for educating students in occupation-based practice and its value and importance when working as future clinicians. Curricula should be planned and centered on the use of occupation throughout the life span and health care continuum to establish the expectation of occupation-based practice from the moment they begin practicing. If programs plan and create curricula that thread the concept of occupation-based practice throughout practice, management, administration, occupational science, program development, research, and theory courses there will be ample opportunity to introduce, apply, and then prove the mastery of use of occupation-based practice. It is important that courses, such as a foundation level course that introduces theories and models, include occupation-based theories such as the OPH. For example, in a research course, the concept of how to study occupation and how to design studies to enhance and evaluate occupation-based practice are skills that are essential for an occupation-based practitioner. In practice courses, the assessment and evaluation of occupation-based practice will occur for determination of a master's. By designing curricula to thread occupation-based practice throughout the program, entry-level therapists will establish belief and knowledge to use and apply occupation throughout the health care continuum.

Throughout entry-level education, schools also need to create similar spaces to those practice settings in which their students will work in the future, spaces such as mock kitchens, apartments, grocery stores, and restaurants. By doing so, it will provide students with the foundational belief and opportunity to apply occupation-based practice. Another area that programs need to incorporate is aligning assignments with occupation-based practice for multiple courses, especially in the practice courses. This will help facilitate students to begin their clinical reasoning skills with an occupation-focused concentration. Within curricula, it is important to introduce occupation-based models and theories; however, a superficial introduction is not sufficient. Most occupation-based models identify occupation as a component of its model on a superficial level, but they do not provide the actual application of occupation to practice. It is imperative that faculty use assignments and integrated fieldwork opportunities to model and reinforce actual use of occupation in a variety of practice settings.

This also leads to the macro level of this issue, which is accreditation. Based on the findings of this study, it is evident the use of occupation-based practice has many benefits for both the clinician and the client; thus, the Accreditation Council for Occupational Therapy Education should review all standards to focus on occupation with the requirement that it be one of the core fundamental concepts of all programs. By doing so, it will ensure that all programs are occupation-based and that all new graduates will have the value and belief of its use and importance.

The third level of education that needs addressing is that of continuing education. It was clear from the participants in this study that there continues to be an issue with therapists misunderstanding or not having a full understanding of what occupation is and what occupation-based practice looks like in practice. This misunderstanding often also creates a

misrepresentation of the profession as well as therapists using more of a medical model approach with clients. This study shows there needs to be more continuing education completed by current clinicians to increase the understanding, belief, and value of occupation-based practice, regardless of the setting or population with which they work.

In addition to continuing education courses, the NBCOT could add the requirement that a percentage or number of hours of continuing education be focused on the core of occupational therapy. This could include courses on occupational therapy theory, occupation throughout the health care continuum, using evidence-based practice in various settings, and/or occupation-based practice. This would ensure those therapists who continue to have confusion regarding the identity of the profession or who are not connected with the AOTA and the current initiatives would become current. This requirement would help diminish the gap of therapist knowledge and understanding of foundational concepts needed to apply occupation-based practice.

Limitations

While this study used the structure and guidelines of the grounded theory approach, there are still areas that could be improved. In a grounded theory approach, it is common to use purposeful sampling. With purposeful sampling, specific populations or settings are chosen to obtain the best information possible. For this study, specific settings were chosen to gather the best information on occupation-based practice. The settings included in this study encompassed school systems, early intervention, rehabilitation hospitals, and home care as part of the inclusion criteria. This resulted in the inability to relate these results to all occupational therapy practice, as there were several settings not included. Another limitation of this study is that it used a qualitative approach. While there is rich and thick data gathered in this study, there is no ability to find the frequency or intensity of occupation-based practice or specific causation or

predictability of its use. Another limitation of this study is there is no exploration about what stage the therapists felt they learned or developed the belief in the use of occupation-based practice. This may have been interesting to learn more about to determine if there was any connection with when they started or the extent to which they valued occupation-based practice.

The initial proposal included a phase of the study in which photovoice would be used to further understand and gain further insight into how therapists conceptualize occupation-based practice. It would have allowed the researcher to see through the eyes of the therapist via a photo the therapist had taken to further interpret the use of occupation-based practice. There were three participants who agreed to photograph occupation-based practice; however, privacy restrictions at facilities prohibited any photographs from being taken; subsequently, no photo-elicited interviews occurred. A final limitation of this study related to personal bias. The researcher used multiple strategies to remove personal bias by engaging in reflexivity with the acknowledgment of those biases prior to the study beginning and the use of memos to document personal thoughts and beliefs throughout the stages of the research study. However, because of the embeddedness that a researcher has when using the grounded theory approach, it is difficult to determine if all biases were completely removed.

Recommendations for Further Studies

While this study answered all three of the research questions, it is recommended to complete further research to gain further knowledge and continue to enhance the dynamic process of occupation-based practice model. It would be beneficial to gather more demographic information on each therapist and follow-up on that information. For instance, one area for further exploration is the therapist's type of entry-level degree. This can be followed up by reviewing the accreditation standards and examining whether the differences in focuses increase,

decrease, or do not impact the values and beliefs of therapists in using occupation-based practice. The completion of further research regarding occupational therapy assistants and their use of occupation-based practice is recommended. It would also be beneficial to gather more qualitative data and from other sources (i.e., photovoice, videos, observations, and so forth) to further enhance and confirm or challenge the findings of this study. By providing a visual of what practice looks like, it will assist researchers in creating a measurement tool and determining the frequency of use and the creation of professional development materials.

It would also be valuable to complete a quantitative phase of this study to further study the frequency of the use of occupation-based practice. It would also be possible to have a larger sample and thus increase the ability to generalize the findings to more therapists and settings. To measure frequency, it is recommended to complete descriptive studies to explore frequencies to begin preliminary quantitative work. The completion of program evaluation studies and outcome studies to determine effectiveness of an occupation-based approach using quasi-experimental designs would follow.

Further research should be done to develop a measurement tool that would allow therapists and/or supervisors to determine whether, and how frequently, therapists are using occupation-based practice in their daily practice in a variety of settings. Additional uses for this for assessment are for student evaluation on Level I and Level II fieldwork, standardization of measurement for simulation, program evaluation, correlation with client satisfaction, and therapist professional development. The structure of the tool will include the constructs in the model of authentic occupation, meaning and purposeful value, therapeutic intent, and engaged occupations. More specifically, this measurement tool would consist of four different scales that are summative, with lower scores on each scale being medical model-based and higher scores

would be occupation-based practice. After the creation of this measurement tool, methodological studies to establish psychometric properties specific to reliability and validity are necessary. This measurement tool would assist in determining where on the continuum the construct lies, from the medical model to occupation-based. After identifying where the therapeutic interactions were on the continuum, therapists or administrators could assess the problem if therapists are not using occupation-based practice. By completing a needs assessment, a therapist or administrator could examine the four main construct areas (physical environment, client, therapist, and systems) and determine which area or areas requires improvement in order to use occupation-based practice. This will require extensive research but is necessary if the AOTA wants occupation-based practice to be the primary means of therapeutic interactions across the life span and throughout all practice settings.

Conclusion

This study explored how therapists conceptualize occupation-based practice, the constructs that comprise occupation-based practice, and the facilitators and barriers to using occupation-based practice. Therapists across multiple settings were found to value and use occupation-based practice. The participants defined occupation and how it is beneficial in practice to the client and the therapist, and how it improves the unique value of the profession. Through a grounded theory approach, the discovery of the interconnecting four main constructs occurred. These include occupation-based practice of authentic occupation, meaningful and purposeful value, therapeutic intent, and resulting in engaged participation. These constructs determine where on the continuum of the theory of the dynamic process of occupation-based practice each therapeutic interaction lands (from the medical model to occupation-based). The theory provides a description and rationale of how a therapist uses his or her decision-making

process for therapeutic interactions. The four components of systems, physical environment, therapist, and client, result in the actual practice, which lies on the continuum from the medical model to occupation-based practice. These findings will help inform future research, practice, and education.

The current literature and this study agree that therapists value occupation-based practice; however, there are no current studies that evaluate the frequency of its use throughout the health care continuum. The literature and this study also agree that the profession continues to have identity issues regarding not understanding and the inability to articulate the purpose and value of occupational therapy. There were multiple studies that also stated facilitators and barriers to using occupation-based practice in a variety of settings. However, there is not any current literature that attempts to articulate the constructs of occupation-based practice and their relationship with the decision-making process that therapists use when determining each therapeutic interaction.

The foundational theories of the OPH (Wilcock, 2006; Wilcock & Hocking, 2015) and the diffusion of innovation (Rogers, 2003) were used to guide the interpretation of findings. These theories assisted in theme development. The study also resulted in implications for practice and education. These implications are to incorporate occupation-based practice to improve client outcomes, further define the unique value of occupational therapy to other professions and reimbursement bodies, and improve therapist fulfillment and support for using occupation-based practice. In education, the implications include occupation-based practice in continuing education, throughout curricula, and having a requirement through the NBCOT to include foundational educational requirements. While this study had results that provide the profession with a new theory to gauge the use of occupation-based practice, there are limitations

and the need for further research to evaluate this theory and create a measurement tool. This study provides therapists the framework of the constructs for occupation-based practice and the decision-making process for each therapeutic interaction.

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Appendix A

Recruitment E-Mail to Potential Participants

Title of Study: Occupation-Based Practice in Occupational Therapy

Principal investigator:

Sarah M. Psillas, MS OTR/L, CEIS

Co-investigator:

Wendy B. Stav, Ph.D., OTR/L, SCDCM, FAOTA

College of Health Care Sciences

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Institutional Review Board

Nova Southeastern University

Office of Grants and Contracts

(954) 262-5369/Toll Free: 866-499-0790

IRB@nsu.nova.edu

Description of Study: Sarah P. is a doctoral student at Nova Southeastern University engaged in research for the purpose of satisfying a requirement for a Doctor of Philosophy degree. The purpose of this study is to gather rich data to define what practicing occupational therapists outline occupation and occupation-based practice to be and how it is utilized in practice. The intent of this study is to create a theory based on the data collected to further understand occupation-based practice throughout the field of occupational therapy.

If you agree to participate, you will be asked to complete the attached demographic questionnaire. This questionnaire will help the writer identify basic demographic information. You will then be asked to complete a one-on-one interview or a focus group that will be used to assist the writer in pulling information from the data to create a theory. Some participants will

also be invited to participate in a follow up interview with use of photographs to help create further discussion for theory building. If you are invited to the additional phase of the study, further descriptions and instructions will be provided.

Risks/Benefits to the Participant: There may be minimal risk involved in participating in this study. There are no direct benefits to for agreeing to be in this study. Please understand that although you may not benefit directly from participation in this study, you have the opportunity to enhance knowledge necessary to assist in the creation of a theory of the use of occupation-based practice to lead to further studies and possible measurement tools with further research. If you have any concerns about the risks/benefits of participating in this study, you can contact the investigators and/or the university's human research oversight board (the Institutional Review Board or IRB) at the numbers listed above.

Cost and Payments to the Participant: There is no cost for participation in this study. Participation is completely voluntary and no payment will be provided.

Confidentiality: Information obtained in this study is strictly confidential unless disclosure is required by law. All data will be secured in a locked filing cabinet and a password locked computer. Your name will not be used in the reporting of information in publications or conference presentations.

Participant's Right to Withdraw from the Study: You have the right to refuse to participate in this study and the right to withdraw from the study at any time without penalty.

I have read this letter and I fully understand the contents of this document and voluntarily consent to participate. All of my questions concerning this research have been answered. If I have any questions in the future about this study they will be answered by the investigator listed above or his/her staff.

I understand that the completion of this questionnaire implies my consent to participate in this study.

Warm regards,

Sarah M. Psillas, MS OTR/L, CEIS

Appendix B

Consent Form

Consent Form for Participation in the Research Study Entitled

Occupation-Based Practice in Occupational Therapy

Funding Source: None.

IRB protocol #

Principal investigator

Sarah M. Psillas, MS OTR/L, CEIS

Co-investigator

Wendy B. Stav, Ph.D., OTR/L, SCDCM, FAOTA

3301 College Avenue

Fort Lauderdale, FL 33314

For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

Site Information
Nova Southeastern University

Center for Psychological Studies

3301 College Avenue

Fort Lauderdale, FL 33314

What is the study about?

You are invited to participate in a research study. The goal of this study is to understand what occupation and occupation-based practice mean to occupational therapy practitioners. The aim of

the study is to understand the constructs that make up these concepts and the relationships between them in order to create a theory grounded in the data.

Why are you asking me?

We are inviting you to participate because you are a current occupational therapy practitioner working with clients full-time. There will be between 5 and 10 participants in this research study.

What will I be doing if I agree to be in the study?

You will answer a short demographic questionnaire. The questionnaire should take you no more than 10 minutes. You will also be interviewed or be part of a focus group conducted by the researcher, Mrs. Psillas. Mrs. Psillas will ask you questions about occupation and occupation-based practice. The interview and/or focus group will last no more than 60 minutes. If during the first phase of the study, the researcher identifies you as a key informant, you may be invited to participate in photovoice. If this is the case, further description and instructions will be provided.

Is there any audio or video recording?

This research project will include audio recording of the interview. This audio recording will be available to be heard by the researcher, Mrs. Sarah Psillas, personnel from the IRB, and the dissertation chair, Dr. Wendy Stav. The recording will be transcribed by Mrs. Sarah Psillas. Mrs. Sarah Psillas will use earphones while transcribing the interviews or be in a private closed room to guard your privacy. The recording will be kept securely in Mrs. Psillas' office in a locked desk, to which only the researcher has the key to. The recording will be kept for 36 months from the end of the study. The recording will be destroyed after that time by deleting the files. Because your voice will be potentially identifiable by anyone who hears the recording,

your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the tape as described in this paragraph.

What are the dangers to me?

Risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day. Being recorded means that confidentiality cannot be promised, although every effort will be made to maintain confidentiality throughout the research and analysis process. If you have questions about the research, your research rights, or if you experience an injury because of the research please contact Mrs. Psillas at (603) 547-0143. You may also contact the IRB at the numbers indicated above with questions about your research rights.

Are there any benefits to me for taking part in this research study?

There are no benefits to you for participating.

Will I get paid for being in the study? Will it cost me anything?

There are no costs to you or payments made for participating in this study.

How will you keep my information private?

The questionnaire will not ask you for any information that could be linked to you. The transcripts of the tapes will not have any information that could be linked to you. As mentioned, the recordings will be deleted 36 months after the study ends. All information obtained in this study is strictly confidential unless disclosure is required by law. The IRB, regulatory agencies, or Dr. Wendy Stav may review research records.

What if I do not want to participate or I want to leave the study?

You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before**

the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Other Considerations:

If the researchers learn anything which might change your mind about being involved, you will be told of this information.

Voluntary Consent by Participant:

By signing below, you indicate that

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled *Occupation-Based Practice in Occupational Therapy*

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____

Appendix C

Demographic Questionnaire

1. What year were you born?
    a. Enter year
2. What is your gender?
    a. Open answer
3. Are you of Hispanic, Latino, or Spanish origin?
    a. Yes
    b. No
4. How would you describe yourself? (Check as many as applicable.)
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Mixed race
    g. Other
5. What year did you pass your NBCOT board certification exam?
    a. Enter year
6. How many years have you been practicing as an occupational therapist?
    a. Enter number
7. What is the highest degree or level of school you have completed? (If you're currently enrolled in school, please indicate the highest degree you have *received.*)

a. Bachelor's degree
b. Master's degree
c. Professional degree (e.g. OTD, DrOT, DOT)
d. Doctorate (e.g. PhD, EdD)

8. What previous settings have you previously worked at throughout your career? (Please select all that apply.)
    a. Pediatrics: School System
    b. Pediatrics: Early Intervention
    c. Pediatrics: Outpatient
    d. Pediatrics: Acute Care
    e. Adults: Acute Care
    f. Adults: Outpatient
    g. Adults: Home Care
    h. Geriatrics: Skilled Nursing Facility
    i. Geriatrics: Home Care
    j. Mental Health: Inpatient
    k. Mental Health: Geriatric
    l. Mental Health: Pediatrics
    m. Other: (fill in the blank) _____
9. What is the current setting at which you work full-time?
    a. Pediatrics: School System
    b. Pediatrics: Early Intervention
    c. Pediatrics: Outpatient

d. Pediatrics: Acute Care

e. Adults: Acute Care

f. Adults: Outpatient

g. Adults: Home Care

h. Geriatrics: Skilled Nursing Facility

i. Geriatrics: Home Care

j. Mental Health: Inpatient

k. Mental Health: Geriatric

l. Mental Health: Pediatrics

m. Other: (fill in the blank) _____

Appendix D

Semi-Structured Interview Question Schedule

Prior to the start of the interview, each participant will be provided a printed copy of the operational definition of occupation-based practice. The participant will have time to read the definition prior to any questions being asked.

1. What is occupation?
2. What is occupation-based practice and what does it look like?
    a. What does occupation-based practice look like?
    b. Can you give me an example?
    c. Can you describe that further?
3. Tell me about how you typically use occupation-based practice with your clients?
4. Have you seen any differences in client outcomes when using occupation-based practice to be the same or different?
5. What makes it easy or difficult to use occupation-based practice?

Participants will then be shown a picture of the Diffusion of Innovation adopters of change and will be provided a brief explanation and example of each category.

6. Where would you place yourself along the continuum of adopting the use of occupation-based practice?
    a. Can you explain why you chose (adoption category identified)?

    Being

7. When choosing interventions, how do you find out what is meaningful to your client/patient?
8. How do you use what is meaningful to your client to treatment plan?
9. Is finding meaning important to be able to use occupation-based practice?

    Becoming

10. How does your client/patient's meaningful occupations relate to goal setting?
11. How do you determine a client's highest occupational potential?

    If identified as a key informant:

12. Now that I understand your view on occupation-based practice, over the course of the next week, would you be willing to take a photograph of what occupation-based practice is?
    a. I will provide you with the instructions, e-mail to send it to, and potential times to have a brief following up meeting after I have received your photograph.

Appendix E

Semi Structured Discussion Guide for Focus Group

Prior to the start of the interview, each participant will be provided a printed copy of the operational definition of occupation-based practice. The participant will have time to read the definition prior to any questions being asked.

1. Could everyone please take turns and introduce yourself. Please state your name, where you are working, and how many years you have been a practicing occupational therapist.
2. Please explain what you think occupation is and how it connects with our daily practice in occupational therapy.
3. Please describe how you define occupation-based practice.
    a. How do you typically use occupation-based practice with your clients?
    b. Have there ever been times when you wanted to use an occupation-based approach, but could not?
        i. If so, what was/were the barrier(s) to your ability to use occupation-based approaches?
4. Could you describe any facilitators or barriers you feel there are in your ability to use occupation-based practice based on your setting.
    a. If you could change anything, what would it be and why?

Appendix F

Instructions for Photovoice

If you are receiving this e-mail, it is because you have been chosen to participate in the second part of this research study. The purpose of this study is to gather rich data to define what practicing occupational therapists outline occupation and occupation-based practice to be and how it is utilized in practice. The intent of this study is to create a theory based on the data collected to further understand occupation-based practice throughout the field of occupational therapy. The use of a photograph (or photographs if you have more than one) will be used in order to facilitate a conversation surrounding occupation-based practice. Photovoice is a method using in research in which a photograph is taken as a means to deepen the understanding of a concern or concept (Palibroda, Kriegg, Murdock, & Havelock, 2009). For the next week, please take a photograph any time you see or use occupation-based practice. After this week, please send your image(s) to the researcher via e-mail below and you will be contacted by the researcher to complete a follow up interview (face-to-face or virtual) to gather the story behind the photograph(s) and its relationship to occupation-based practice. Please use the following guidelines when taking your picture for this portion of the study:

1. Photograph an intervention session in which occupation-based practice is being used.
    a. This may be the environment that is set up or an actual intervention session.
2. If a client or patient is in the picture, only photograph the back of the client so there is no chance of breaching confidentiality.
3. Do not include any material that would be identifying clients or the place at which you work.
    a. Examples: Signs, name plates, name tags, etc.
4. Upload photo to: occupationbasedpractice@gmail.com

Appendix G

Semi-Structured Interview Question Schedule for Photovoice

Note: During this virtual interview, the photograph(s) will be put up on the computer screen so that the participant and the research are both looking at the image.

1. Please explain this photograph to me.
2. Explain how this demonstrates occupation-based practice.
3. Did you have any facilitators or barriers to using this intervention?